2345

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

22345

V. S. No. 2. A

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

1 PLACE OF DEATH

County Jasper

Township ..... Registration District No. 417 File No. 127

Village ..... Primary Registration District No. 304 Registered No. .....

City Webb City (No. Tubercular Hospital St., T.B. Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Elysia S. Chedester

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: Jan — (Month) (Day) 1886 (Year)

7 AGE: 40 yrs. 5 mos. ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION (Trade, profession, or particular kind of work): Miner

9 General nature of industry (business or establishment in which employed (or employer)): .....

10 BIRTHPLACE (City or town, State or foreign country): Mo.

10 NAME OF FATHER: John Chedester

11 BIRTHPLACE OF FATHER (City or town, State or foreign country): New S

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): unknown

I CERTIFY THAT THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Floyd Chedester

(Address) Carterville Mo

Filed 6/15, 1920. C. E. McBride Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: June (Month) 14 (Day), 1920 (Year)

17 I HEREBY CERTIFY, that I attended deceased from April 28, 1920, to June 14, 1920, that I last saw him alive on June 14, 1920, and that death occurred, on the date stated above, at 7:35 A.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

23 hrs

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Norman Hazlewood M. D.

June 14, 1920. (Address) Webb City Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death 0 yrs. 1 mos. 21 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? Zinc and lead miner.

Former or usual residence Carterville Mo.

19 PLACE OF BURIAL OR REMOVAL: Wild Rose Cem DATE OF BURIAL: 6/15, 1920

20 UNDERTAKER: W. C. Und. Co ADDRESS: Webb City

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BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1 PLACE OF DEATH

County .....

Township ..... Registration District No. ..... File No. .....
or
Village ..... Primary Registration District No. ..... Registered No. .....
or
City ..... (NO. ..... St.: ..... Ward)

(If death occur hospital or inst give its NAME of street and nu

2 FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX | 4 COLOR OR RACE | 5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

6 DATE OF BIRTH
..... (Month) ..... (Day), 1..... (Year)

7 AGE
.....yrs.....mos.....ds.
If LESS than 1 day,.....hrs. or.....min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9 BIRTHPLACE
(City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER
(City or town, State or foreign country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed....., 191....., ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH
..... (Month) ..... (Day), 191.

17 I HEREBY CERTIFY, that I attended deceased
....., 191....., to....., 19
that I last saw h.....alive on....., 19
and that death occurred, on the date stated above, at.....
The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration).....yrs.....mos.....

CONTRIBUTORY .....
(Secondary)
..... (Duration).....yrs.....mos.....

(Signed) .....

....., 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Caus (1) Means of Injury; and (2) whether Accidental, Suicidal or Hom

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Tran or Recent Residents)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ....., 1

20 UNDERTAKER | ADDRESS