

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

Do not use this space.

26744

1. PLACE OF DEATH

County Chariton Co.
Township Wayland
City (No. Ward)

Registration District No. 173
Primary Registration District No. 5240

File No. 9257/27
Registered No.
St. Ward

2. FULL NAME

Clyde Kenneth Chayburg

(a) Residence No. St. Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb. 9 - 1925

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
2 7 15

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Chariton Co. Mo.
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER William Henry Chayburg

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Chariton Co. Mo.
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Silla Keager

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Chariton Co. Mo.
(STATE OR COUNTRY)

14. INFORMANT William H. Chayburg
(Address) Quinn Hill R. 5, Mo.

15. FILED 19..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 24 1927

17. I HEREBY CERTIFY, That I attended deceased from 1 P.M. 9-24-27 to 3 P.M. 7-24-27 1927 that I last saw h. i. m. alive on 7-24-27 at 3 P.M. and that death occurred, on the date stated above, at 8 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Child perfectly well according to parents had convulsion & was in convulsion when saw child. Child died in convulsion.
(duration) yrs. mos. da.

CONTRIBUTORY 4 hours later
(SECONDARY)

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? No. DATE OF

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) Robert H. Dillman, M.D.
, 19 (Address) Wahshburn, Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

McCray Cemetery Sept 25, 1927

20. UNDERTAKER ADDRESS

Ancher Miss. Hillsville Mo.

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

