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

Do not use this space.

39175

1. PLACE OF DEATH
County: Shelby
Township: ~~Clay~~
City: Clarence (No. ..... St. ..... Ward)
Registration District No.: Dr Roy, 827
Primary Registration District No.: 4500
File No.:
Registered No.: 28

2. FULL NAME: Mrs Martha Anderson Cheline
(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. ..... ds. How long in U.S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: John Cheline
6. DATE OF BIRTH (MONTH, DAY AND YEAR): April 10-1845
7. AGE: Years 82 | Months 8 | Days 21 | If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer
9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Sweden.

PARENTS
10. NAME OF FATHER: Andrew Anderson
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Sweden
12. MAIDEN NAME OF MOTHER: Dont Know
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Dont Know

14. INFORMANT: Mrs Sam Rickey
(Address): Clarence Mo

15. FILED: 1-10, 1928 Ray Hamilton
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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16. DATE OF DEATH (MONTH, DAY AND YEAR): Dec. 31 1927

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..., to ....., 19..., that I last saw her alive on Dec. 10, 1927, and that death occurred, on the date stated above, at 3 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Mitral Insufficiency

16 (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY): Senility

(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? No
DID AN OPERATION PRECEDE DEATH? No DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? K Roy
(Signed) ....., M. D
1/7, 1928 (Address) Clarence 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: Maplewood Cemetery
DATE OF BURIAL: Jan 3 1928

20. UNDERTAKER: E E Hopper
ADDRESS: Clarence Mo

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.

JAN 1928