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

Do not use this space.

11749

File No. ____
Registered No. 460

1. PLACE OF DEATH
County: Buchanan — Registration District No. 85
Township: ____ — Primary Registration District No. 1001
City: St. Joseph, (No. St. Joseph's Hospital St. ____ Ward)

2. FULL NAME Henry William Challis,

(a) Residence. No. 2611 Seneca St., ____ Ward. ____
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. ____ mos. ____ ds. How long in U.S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 16, 1862

7. AGE Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
67	10	25	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Live Stock Broker
(b) General nature of industry, business, or establishment in which employed (or employer): Live Stock,
(c) Name of employer: Self,

9. BIRTHPLACE (CITY OR TOWN) Unknown,
(STATE OR COUNTRY) Indiana,

PARENTS
10. NAME OF FATHER John L. Challis,
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Unknown
(STATE OR COUNTRY) New Hampshire,
12. MAIDEN NAME OF MOTHER Emma A. Little,
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Unknown,
(STATE OR COUNTRY) New Hampshire,

14. INFORMANT Dr Grace DeVall
(Address) Fairbury, Nebr.

15. FILED April 14 1930, 19____ John E. Ott (REGISTRAR)

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 11 1930

17. I HEREBY CERTIFY, That I attended deceased from April 11 1930 to April 11 1930, that I last saw him alive on April 11, 1930, and that death occurred, on the date stated above, at 10.30 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Bronchio-pneumonia
21 D
1 D

(duration) ____ yrs. ____ mos. 6 ds.

CONTRIBUTORY (SECONDARY) Fractured femur
Auto accident (duration) ____ yrs. ____ mos. 7 ds.
outside city limits ?

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? Clinical

(Signed) John E. Bonn, M.D.
April 12, 1930 (Address) St Joseph 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: Fairbury, Nebr.
DATE OF BURIAL: Apr. 14 1930

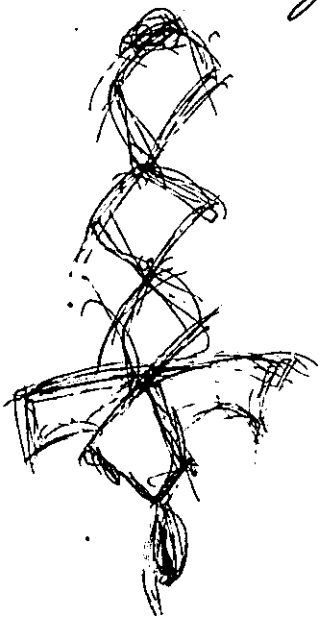
20. UNDERTAKER: Wheaton-Bigale & Bauman Funeral Home
ADDRESS: 319 S. 10 St.

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.

Dr. John S. Byrne

To

[redacted]



Dr Byrne.

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.
County: Buchanan — Registration District No.: 85 — File No.: 11749
Township: — Primary Registration District No.: 1001 — Registered No.: 460
City: St. Joseph (No. ..., St. ..., Ward)

2. FULL NAME: Henry William Challis

(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: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): W

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE — YEARS | MONTHS | DAYS | If LESS than 1 day, ... hrs. or ... min.

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)
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY)

14. INFORMANT
(Address)

15. FILED 9-17, 1930. John G. Utz
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr-11 1930

17. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19..., that I last saw h... alive on ..., 19..., and that death occurred, on the date stated above, at ... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Bronchio pneumonia —
Auto injury — treatment J.X. Cheadle — on highway
(duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) auto accident on highway 4 miles outside of city
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH
DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) ..., M. D
, 19 (Address)

188C
207

*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 19

20. UNDERTAKER — ADDRESS

SUPPLEMENTARY

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.
REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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