

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

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.

NOV 25 1932

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

Do not use this space.

36305

1. PLACE OF DEATH
 5-8 County Lincoln Registration District No. 496
 1 Township Brookfield Primary Registration District No. 3927
 7 City Brookfield (No. 209, W. Brook) St. 2 Ward)

2. FULL NAME Robert Thomas Chrisman
 (a) Residence, No. 209 W. Brooks St. _____ Ward _____
 (Usual place of abode)
 Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>M</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Louisa Chrisman</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Mar-3-1856</u>		
7. AGE	YEARS <u>76</u>	MONTHS <u>9</u>
		DAYS <u>4</u>
		IF LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>Retired</u>	
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. <u>2 Hand Dealer</u>	
	10. Date deceased last worked at this occupation (month and year) _____	
	11. Total time (years) spent in this occupation _____	
12. BIRTHPLACE (CITY OR TOWN) <u>Des Moines</u> 2 (STATE OR COUNTRY) <u>Iowa</u>		
MOTHER FATHER	13. NAME <u>Michael Chrisman</u>	
	14. BIRTHPLACE (CITY OR TOWN) <u>Not known</u> 31 (STATE OR COUNTRY)	
	15. MAIDEN NAME <u>Not known</u>	
	16. BIRTHPLACE (CITY OR TOWN) <u>Not known</u> (STATE OR COUNTRY)	
17. INFORMANT <u>Mrs. Bernice Wallace</u> (ADDRESS) <u>Brookfield Mo</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Rose Hill</u> DATE <u>Nov-9-1932</u>		
19. UNDERTAKER <u>C. W. Hill</u> (ADDRESS) <u>Brookfield Mo</u>		
20. FILED <u>11-8</u> 1932 <u>W. S. Jenkins</u> Registrar.		

2 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov-7 1932

22. I HEREBY CERTIFY, That I attended deceased from _____, 1927, to Nov. 7, 1932
 I last saw him alive on Nov 7, 1932 Death is said to have occurred on the date stated above, at 12:30 A.
 The principal cause of death and related causes of importance were as follows:
myocarditis
9:30 9:50 10:2 9:50
 Other contributory causes of importance: Hypertension

Name of operation _____ Date of _____
 What test confirmed diagnosis? None Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? no Date of injury _____, 19____
 Where did injury occur? no
 (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? no
 If so, specify _____
 (Signed) W. B. Simpson, M. D.
 (Address) Brookfield Mo.

