

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.

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

Borden
Do not use this space.

1. PLACE OF DEATH

County *Boone*

Registration District No. *72*

File No. *7804*

Township

Primary Registration District No. *4041*

Registered No. *8*

City *Centralia* No. _____

St. _____ Ward _____

2. FULL NAME *John Albert Chance*

(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. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male*

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 *Louise Sytore Chance*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *July 22 - 1849*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. *84 7 10*

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *Merchant*

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Bluffs Ill.*

13. NAME *Louise H. Chance*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Dover Delaware*

15. MAIDEN NAME *Roberts*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Kentucky*

17. INFORMANT (ADDRESS) *A. Bishop Chance Centralia Mo*

18. BURIAL, CREMATION, OR REMOVAL *Centralia Mo Cem* DATE *3/4/34* 1934

19. UNDERTAKER (ADDRESS) *W. McDonald Centralia Mo*

20. FILED *3/3/34* 1934 *J. J. Harrison* Registrar.

7 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *March 2* 1934

22. I HEREBY CERTIFY, That I attended deceased from *Feb 26* 1934, to *March 2* 1934

I last saw him alive on *March 2* 1934. Death is said

to have occurred on the date stated above, at *8:15 A.M.*

The principal cause of death and related causes of importance were as follows:

Central Thrombosis Date of onset *2/26*

825
Other contributory causes of importance: *Septic Pneumonia*

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____ 19 _____

Where did injury occur? _____ (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) *Frank W. Borden* M. D.

(Address) *Centralia Mo*

