

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

3086  
Do not use this space.

1. PLACE OF DEATH  
 (a) County Jasper Registration District No. 411  
 (b) Township Jordan Primary Registration District No. 2097 Registered No. \_\_\_\_\_  
 (c) City Jordan (d) Street No. Freeman Hospital St. \_\_\_\_\_  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Chester A Best 230  
 (a) Residence, No. 811 Memphis St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

**PERSONAL AND STATISTICAL PARTICULARS**

**MEDICAL CERTIFICATE OF DEATH**

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Myrtle  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jul 18, 1883  
 7. AGE YEARS 54 MONTHS 5 DAYS 28 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 15, 38  
 22. I HEREBY CERTIFY, that I attended deceased from Aug 15, 37 to Jan 15, 38  
 I last saw him live on Jan 15, 38 Death is said to have occurred on the date stated above, at 9:20 PM  
 The principal cause of death and related causes of importance were as follows:

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Smelter  
 9. Industry or business in which work was done, as saw mill, bank, etc. Employee  
 10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

Chronic nephritis Date of onset \_\_\_\_\_  
 Other contributory causes of importance: 131

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Savannah MO.  
 13. NAME Samuel Best  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Jessing  
 15. MAIDEN NAME Alice Williford  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) No record

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

17. INFORMANT (ADDRESS) Myrtle Best  
 18. BURIAL, CREMATION, OR REMOVAL (ADDRESS) Mem Park DATE Jan 18, 38  
 19. FUNERAL DIRECTOR (ADDRESS) Hurlbut and Co  
 20. FILED 1-18-38 Ed Jasper Local Registrar

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? \_\_\_\_\_  
 If so, specify H. L. Williford (Signed) \_\_\_\_\_, M. D.  
 (Address) Jordan MO

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

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MO. STATE BOARD OF HEALTH

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**STATEMENT BY LICENSED EMBALMER**

I, ....., Licensed Embalmer No.....

hereby certify that the body recorded on the reverse side of this certificate was embalmed by.....

..... L. E. ....

No. .... or by....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

..... Licensed Embalmer No.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**