REC'D MAY 22 1939

Dr Gronoway

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

15449
Do not use this space.

1. PLACE OF DEATH
(a) County Macon
(b) Township
(c) City Macon
(d) Street No. ..... 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.

Registration District No. 533
Primary Registration District No. 3027
Registered No. 45

2. PRINT FULL NAME Ella K. McChesney
(a) Residence, No. ..... St. ☑
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widow
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Thomas H. McChesney
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan. 14-1876
7. AGE YEARS 83 MONTHS 3 DAYS 6 If LESS than 1 day, ... hrs. or ..... min.

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

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ray Co. Mo.

FATHER
13. NAME Joshua Armstrong
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

MOTHER
15. MAIDEN NAME Sarah Ann Jacobs
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

17. INFORMANT (ADDRESS) H. C. McChesney Macon, Mo.
18. BURIAL, CREMATION, OR REMOVAL PLACE Jacobs Cem. Ray Co. DATE 4 22 39
19. FUNERAL DIRECTOR (NAME) (ADDRESS) Stephens & Goodding Macon, Mo.
20. FILED 5/5 1939 Leota Newton Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4 - 20 - 1939
22. I HEREBY CERTIFY, That I attended deceased from Feb. 25, 1939, to April 20, 1939
I last saw her alive on April 20, 1939 Death is said to have occurred on the date stated above, at 4:15 m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Cardio-vascular renal	5 yrs. ago
Other contributory causes of importance: neck 7 Fracture of right femur	2/25/39

Name of operation ..... Date of .....
What test confirmed diagnosis? Clinical. Was there an autopsy? No

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) G. P. Gronoway, M. D.
(Address) Macon, Mo.

(Licensed Embalmer's Statement on Reverse Side)

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

1946

RECEIVED
District Health Officer No. 10
District File Number 10-39-856
Date Filed MAY 6 1939

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, O. L. Stephens, or by

Registered Apprentice No. ....., working under my personal supervision.

Signed O. L. Stephens

Licensed Embalmer No. 3057

P. O. Address Macon, Mo.

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.)

If this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

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

15-449
Do not use this space.

1. PLACE OF DEATH
(a) County Macon — Registration District No. 533
(b) Township — Primary Registration District No. 3027 — Registered No. 45
(c) City Macon — (d) Street No. ..... 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 Ella K. McChesney
(a) Residence, No. ..... St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Wid

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.
83	3	6	

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as 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)

FATHER
13. NAME
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER
15. MAIDEN NAME
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL
PLACE ..... DATE ..... 19..

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED ..... 19.. ..... Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4-20, 1939

22. I HEREBY CERTIFY, That I attended deceased from ..... 19.. to ..... 19.. I last saw h. alive on ..... 19.. Death is said to have occurred on the date stated above, at ..... m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Cardio-Vascular Renal	
Other contributory causes of importance: Fracture of neck of right femur	

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? Accident Date of injury 7-25, 1939
Where did injury occur? Macon, Mo. (Specify city or town, county, and State)
Specify whether injury occurred in Industry, in home, or in public place. In home
Manner of injury Fall in home
Nature of injury Fracture neck r. femur

24. Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....
(Signed) T. P. Gronoway, M. D.
(Address) Macon Mo.

SUPPLEMENTARY

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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.