

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

29883

Do not use this space.

REC'D SEP 19 1939

1. PLACE OF DEATH

(a) County Peru Registration District No. 608
(b) Township St. Virginia Primary Registration District No. 3872
(c) City St. Louis (d) Street No. _____ Registered No. _____
(e) Length of residence in city or town where death occurred yrs. mos. da. (f) How long in U.S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME

(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

MEDICAL CERTIFICATE OF DEATH

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Mar
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 8-18-39
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8-18-1939
22. I HEREBY CERTIFY that I attended deceased from 8-18-1939 to 8-18-1939
I last saw her alive on 8-18-39, 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:

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 _____

Premature (about 8 mo. preg)
Date of onset _____
Other contributory causes of importance: St

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Holland mo

FATHER 13. NAME Wade B C Channell

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Louis Tenn

MOTHER 15. MAIDEN NAME Ruth Lester

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

17. INFORMANT (ADDRESS) Ruth Lester Channell
Holland, mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Mt. Zion DATE 8-17-39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) W. E. Freeman
St. Louis

20. FILED 918 W. E. Freeman
Local Registrar

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? _____
If so, specify _____
(Signed) W. E. Freeman, M. D.
(Address) Holland, Mo

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

RECEIVED

District Health Officer No. 3

District File Number 939-570

Date Filed 9/12/39

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, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.

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1. PLACE OF DEATH

(a) County Pemisesat Virginia Registration District No. 6053-
(b) Township Virginia Primary Registration District No. 5872 Registered No. _____
(c) City _____ (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 54 yrs. mos. ds. (f) How long in U. S., if of foreign birth _____ yrs. mos. ds.

2. PRINT FULL NAME Baby - Chancell (Chanel)

(a) Residence, No. _____ 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

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 8-18-1939
7. AGE YEARS MONTHS DAYS 0 If LESS than 1 day, _____ hrs; or _____ min.
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 Wade B. Chancell

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 98 9/29/39 D. C. McLean Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8-18-1939

22. I HEREBY CERTIFY, That I attended deceased from _____ 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 _____

Other contributory causes of importance: _____

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? _____

If so, specify _____ (Signed) D. C. McLean, M. D.

(Address) Halland

SUPPLEMENTARY

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

