

Registration District No. **322** Primary Registration District No. **222 5446** Registrar's No. **17**

1. PLACE OF DEATH:
(a) County **Greene**
(b) City or town **Fair Grove Mo.**
(c) Name of hospital or institution: **R# 2**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME **CHARLES CHEFFEY**
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

4. Sex **male** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Single**
6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: **April 6, 1921**
(Month) (Day) (Year)

8. AGE: Years **18** Months **5** Days **12** If less than one day _____ hr. _____ min.

9. Birthplace: **Greene Co. Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

11. Industry or business **On Farm**

12. Name **J. C. Cheffey**

13. Birthplace **Mo.**
(City, town, or county) (State or foreign country)

14. Maiden name **Margaret Bosty**
15. Birthplace **Menn**
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature **Margaret Cheffey**

(b) Address **Fair Grove R# 2**

17. (a) **Burial** (b) Date thereof **Sept 21-1939**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **St. Mary's Cemetery**

18. (a) Signature of funeral director **St. Mary's Co.**

(b) Address **Springfield Mo.**

19. (a) **Sept 20 1939** (b) **Allen Barnes**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo** (b) County **Greene**
(c) City or town **Fair Grove**
(If outside city or town limits, write "RURAL")
(d) Street No. **R# 2**
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Sept** day **18**
year **1939** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him **dead** on **Sept 18**, 19**39**;
and that death occurred on the date and hour stated above.

Immediate cause of death: **Gun shot wound through chest (22 bullet)**

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) **accident**

(b) Date of occurrence **Sept 18 1939**

(c) Where did injury occur? **Ferguson R. 2 Greene Mo.**
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
on farm (in corn field)

While at work? **no** (Specify type of place) (e) Means of injury **Rifles**

23. Signature **W. H. White** (M. D. or other) **M.D.**
Address **Carver Greene County** Date signed **9/19/39**

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

Rev. 6-17-39
1 X19511

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.

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.