

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.

DEC 11 1939

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

39099  
Do not use this space.

1. PLACE OF DEATH

(a) County Buchanan Registration District No. 83  
 (b) Township St. Joseph Primary Registration District No. 1001 Registered No. 1233  
 (c) City Saint Joseph (d) Street No. 819 South 15th Street 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 Delbert Willison, Jr.

(a) Residence, No. 819 South 15th St. 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 Male 4. COLOR OR RACE White 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) November 28, 1939

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
0 0 0

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. None  
 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) Saint Joseph, Missouri  
 (STATE OR COUNTRY)

FATHER 13. NAME Chester Delbert Willison

14. BIRTHPLACE (CITY OR TOWN) Underwood, Iowa  
 (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME Margaret Owen

16. BIRTHPLACE (CITY OR TOWN) Beacon, Iowa  
 (STATE OR COUNTRY)

17. INFORMANT (ADDRESS) Chester Delbert Willison  
819 South 15th Street

18. BURIAL, CREMATION, OR REMOVAL PLACE Oskaloosa, Iowa DATE Nov. 30, 1939

19. FUNERAL DIRECTOR (NAME) E. R. Sidenfaden F. Home  
 (ADDRESS) 602 South 10th Street

20. FILED Nov 29 1939 A. J. Neelbush  
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) November 29, 1939

22. I HEREBY CERTIFY, That I attended deceased from Nov. 28, 1939 to Nov. 29, 1939

I last saw him alive on Nov. 29, 1939. Death is said to have occurred on the date stated above, at 6:30 A.M.

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

Morbus Caeruleus

Date of onset Nov 26 1939

Other contributory causes of importance: 114W

Name of operation none 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) London O. Wright M.D. M. D.  
 (Address) 845 So. 19th St. Saint Joseph, Mo.

**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, <sup>and</sup> or by.....

*Mollie E. Sidenfaden*, Registered Apprentice No. *145*  
working under my personal supervision.

Signed *R. V. Werst*

Licensed Embalmer No. *3876*

P. O. Address *St. Joseph, 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.**