

DEED MAR 18 1940

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

7603  
Do not use this space.

1. PLACE OF DEATH  
(a) County Oregon Registration District No. 6-3  
(b) Township Rake Grove Primary Registration District No. 5-4  
(c) City Alton, Mo Rt (d) Street No. \_\_\_\_\_  
(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 Lillie May Chaplin  
(a) Residence, No. Oregon Co Rural St.  (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX fw 4. COLOR OR RACE wht 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) widow  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Frank Chaplin  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Mar 5, 1871  
7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
68      9      29  
OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife  
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) Irby, Missouri  
FATHER 13. NAME Geo Stiler 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ky.  
MOTHER 15. MAIDEN NAME Mary Slater 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Illinois  
17. INFORMANT (ADDRESS) Mrs. A. R. Bruner Alton, Mo  
18. BURIAL, CREMATION, OR REMOVAL PLACE Cops DATE 1-3-40  
19. FUNERAL DIRECTOR (NAME) (ADDRESS) Robertson's West Plains, Mo  
20. FILED \_\_\_\_\_ 19 \_\_\_\_\_

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-2-1940  
22. I HEREBY CERTIFY, That I attended deceased from 1-1-1940 to 1-2-1940  
I last saw h. alive on 1-1-1940 Death is said to have occurred on the date stated above, at 4:30 m.  
The principal cause of death and related causes of importance were as follows:  
Coronary Heart Disease  
Hypertension  
Arteriosclerosis  
Other contributory causes of importance: 121  
Chronic Nephritis  
General Atherosclerosis  
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) [Signature], M. D.  
(Address) [Address]  
Local Registrar. 56

K. 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.

RECEIVED

District Health Officer No. 5,

District File Number 240-246

Date Filed 3840

Signed Emily A. Roberts

Licensed Embalmer No. 3432

P. O. Address West Plains

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.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

State File No. 7603

Registration District No. 632

Primary Registration District No. 5847

Registrar's No. \_\_\_\_\_

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

1. PLACE OF DEATH:

(a) County Oregon

(b) City or town Castine  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: \_\_\_\_\_  
(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 Lillie May Chaplin

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced Wid

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband, or wife, if alive \_\_\_\_\_ years

7. Birth date of deceased \_\_\_\_\_ (Month) (Day) (Year)

8. AGE: Years 68 Months 9 Days 29 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) April 13 - 1940 (b) George Johnson  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Oregon

(c) City or town Rural  
(If outside city or town limits write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

DEATH CERTIFICATION

20. DATE OF DEATH: Month 1 day 2 year 1940 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_; that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature C. W. Cooper (M. D. or other) \_\_\_\_\_

Address Thayer Date April 13 1940

SUPPLEMENTARY

