

No. 2
11-10-39
-17-39
X 21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 28253

Registration District No. 185 Primary Registration District No. 5259 Registrar's No. 18

1. PLACE OF DEATH:

(a) County Christian
(b) City or town Raymond Mo. R.R.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Smilee Township
(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 157

8. (a) PRINT FULL NAME Jose W. Chabbon
8. (b) If veteran, name war _____ 3. (c) Social Security No. _____

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

7. Birth date of deceased June 10 1890
(Month) (Day) (Year)

8. AGE: Years 88 Months 1 Days 10 If less than one day _____ hr. _____ min.

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

10. Usual occupation farmer

11. Industry or business _____

MOTHER FATHER
12. Name Newton Chabbon
18. Birthplace Tenn (City, town, or county) (State or foreign country)
14. Maiden name Romaine Kallan
15. Birthplace Tenn (City, town, or county) (State or foreign country)

16. (a) Informant Janice Chabbon
(b) Address Raymond Mo. R.R.

17. (a) Buried (b) Date thereof July 21 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Roller Cemetery

18. (a) Signature of funeral director T. B. Chabbon
(b) Address Osark Mo.

19. (a) 8-15-1940 (b) Josephine Murrill
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Christian
(c) City or town Raymond Mo. R.R. (If outside city or town limit, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 20
year 1940, hour 5 P.M. minute _____ M.

21. I hereby certify that I attended the deceased from June 15, 1940 to June 16, 1940
that I last saw him alive on June 15, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary P.O.

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) _____

(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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature R. R. Hartshorn (M. D. or other) _____

Address Osark Mo. Date signed 9/16-40

Duration _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

RECEIVED
District Health Officer No. 6,
District File Number 940-2524
Date Filed SEP 03 1940

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 T. B. Cheffin
Licensed Embalmer No. 2182
P. O. Address Clark Ave

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.