

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 28411

Registration District No. 266 Primary Registration District No. 5376 Registrar's No. 62

1. PLACE OF DEATH:

(a) County Dent
(b) City or town Norman
(c) Name of hospital or institution: XX
(If not in hospital or institution, write street number or location) 2
(d) Length of stay: In hospital or institution XX
In this community all his life
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dent
(c) City or town Norman Typ
(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.

3. (a) PRINT FULL NAME E. Lewis Lynn Chumley 540

3. (b) If veteran, name war XX 3. (c) Social Security No. _____

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Grace Edith Cavanaugh 6. (c) Age of husband or wife if alive 34 years
7. Birth date of deceased Nov 20 1903
(Month) (Day) (Year)

8. AGE: 36 Years 9 Months 10 Days If less than one day _____ hr. _____ min.

9. Birthplace Dent Co Mo
(City, town, or county) (State or foreign country)

10. Usual occupation farmer

11. Industry or business _____

MOTHER FATHER
12. Name G. H. Chumley
13. Birthplace Rock Castle Co Ky
(City, town, or county) (State or foreign country)
14. Maiden name Jessie Bailey
15. Birthplace Dent Co Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs G. H. Chumley
(b) Address Salem Mo

17. (a) burial (b) Date thereof 9/1/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Catholic Cem

18. (a) Signature of funeral director W. H. Farmer
(b) Address Salem Mo

19. (a) August 31 1940 (b) W. H. Farmer
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 30
year 1940 hour 8 minute 10 A.M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him alive and that death occurred on the date and hour stated above.

Immediate cause of death Suicide by hanging

Due to ill health

Due to _____

Other conditions (include pregnancy within 5 months of death) _____

Major findings: Of operations _____
Of autopsy no

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? 240

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

23. Signature W. H. Farmer (M. D. or other) _____
Address Salem Mo Date signed Aug 30 1940

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

5
6
23
RECEIVED

District Health Officer No. 5,

District File Number. 940935

Date Filed _____

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 Wm. W. McDonald

Licensed Embalmer No. 3806

P. O. Address Salem, Me.

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

State File No. 28411

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 266

Primary Registration District No. 3376

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County Dent
(b) City or town Seymour, IA
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (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.

3. (a) PRINT FULL NAME Lewis Lynn Chumley

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced M

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 36 Months 9 Days 10 If less than one day _____ 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) _____ (b) _____ (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 30 year 1940 hour _____ minute _____ M.

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

Immediate cause of death Suicide by hanging
ill health

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death) 165

Major findings: Of operations _____

Of autopsy _____

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

(a) Accident, suicide, or homicide (specify) Suicide

(b) Date of occurrence Aug 30 - 1940

(c) Where did injury occur? Home in Barr (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home at his home

While at work? _____ (e) Means of injury Hanging

23. Signature O. G. Dillion (M. D. or other)

Address Seymour MO Date signed Oct 8 1940

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

SUPPLEMENTAL

