

STANDARD CERTIFICATE OF DEATH

35106

State File No.

Registration District No. 207

Primary Registration District No. 5286

Registrar's No. 28-28

1. PLACE OF DEATH:

(a) County Clinton
(b) City or town Rural-Coveard
(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 _____ years, months or days

8. (a) PRINT FULL NAME Myrtle Eva Chaimy

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Charles 6. (c) Age of husband or wife if alive 68 years

7. Birth date of deceased: Oct 31-1872 (Month) (Day) (Year)

8. AGE: Years 66 Months 11 Days 11 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business Housewifery

12. Name William Rigdon

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

14. Maiden name Starr Rigdon

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

16. (a) Informant Charles Chaimy

(b) Address Pettabury Mo

17. (a) _____ (b) Date thereof 10-13-40 (Month) (Day) (Year)

(c) Place: burial or cremation Int. Gionent

18. (a) Signature of funeral director J. D. Wynn

(b) Address Pettabury Mo

19. (a) Oct 13-1940 (b) Emmie Chaimy (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Clinton

(c) City or town Plattsburg-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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 12 year 1940 hour 6 am minute _____ M.

21. I hereby certify that I attended the deceased from June 1939, to Oct 17 1940

that I last saw her alive on Oct 11 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Interosclerosis

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 J. D. Reynolds (M. D. or other) _____

Address Plattsburg Mo Date signed 10-13-1940

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

NOV 10 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

James L. Martin

Registered Apprentice No. _____

working under my personal supervision.

Signed _____

James L. Martin

Licensed Embalmer No. *860*

P. O. Address *Plattsburgh*

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. 35706

Registration District No. 207

Primary Registration District No. 6296

Registrar's No. 28

1. PLACE OF DEATH:

(a) County Clinton
(b) City or town Concord
(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 _____
years, months or days

3. (a) PRINT FULL NAME Myrtle Eva CHAINÉY
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex 7 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 Months Days If less than one day
66 11 11 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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) May 24-41 (b) Bernice Chainey
(Date received local registrar) (Registrar's signature)

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) Citizen of foreign country _____ (Yes or No)
If yes, name country _____

20. DATE OF DEATH. Month Oct day 12
year 1946 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 _____

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 J. D. Reynolds (M. D. or other) _____
Address Plattsburg Date signed _____

MEDICAL CERTIFICATION

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

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

ROWENA MOORE

