

FILED NOV 25 1940

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

35905

Do not use this space.

1. PLACE OF DEATH

(a) County New Madrid 2 6 Registration District No. 605
(b) Township Catron Primary Registration District No. 4359 Registered No.
(c) City Catron (d) Street No. 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 2 yrs. mos. 2 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Maschel Chiles
(a) Residence, No. Catron, Missouri 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 <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>10 Oct. 8th, 1938</u>				
7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	<u>2</u>	<u>--</u>	<u>2</u>	
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.			
	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	
FATHER	12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Catron Missouri</u>			
	13. NAME <u>Curtis Leroy Chiles</u>			
MOTHER	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Matthews Missouri</u>			
	15. MAIDEN NAME <u>Martha Treece</u>			
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Sikeston Missouri</u>				
17. INFORMANT <u>C. L. Chiles</u> (ADDRESS) <u>Catron, Mo.</u>				
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Matthews</u> DATE <u>10/11</u> 19 <u>40</u>				
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>none 534</u>				
20. FILED <u>10/10</u> 19 <u>40</u> <u>Dr. G. W. ...</u> Local Registrar.				

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) <u>10-10</u> 19 <u>40</u>
22. I HEREBY CERTIFY, That I attended deceased from <u>10-9-40</u> 19... to <u>10-9-40</u> 19... I last saw her alive on <u>10-9-40</u> 19... Death is said to have occurred on the date stated above, at <u>6:40 A.M.</u> The principal cause of death and related causes of importance were as follows: <u>Laryngeal Diphtheria</u>
Date of onset
Other contributory causes of importance:
Name of operation <u>clinical</u> Date of <u>10/10</u>
What test confirmed diagnosis? <u>clinical</u> Was there an autopsy? <u>no</u>
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) <u>J. H. Gilbert M.D.</u> (Address) <u>Parma, Missouri</u>

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.

RECEIVED

District Health Officer No. 2

District File Number 1140-168

Date Filed 11/12/40

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.....

Licensed Embalmer No.....

P. O. Address.....

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.