

STANDARD CERTIFICATE OF DEATH

State File No. 36098

Registration District No. 719

Primary Registration District No. 5-950

Registrar's No. 13

NOV 21 1940

1. PLACE OF DEATH:

(a) County Putnam
(b) City or town Rural
(c) Name of hospital or institution: ELM TMD
(d) Length of stay: In hospital or institution 2
In this community years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State mo (b) County Putnam
(c) City or town Rural
(d) Street No. Lurona mo R70
(e) If foreign born, how long in U. S. A. years

3. (a) PRINT FULL NAME Joseph-Earl Chadwick

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

4. Sex Male 5. Color or race W- 6. (a) Single, widowed, married, divorced m-
6. (b) Name of husband or wife Margaret Chadwick 6. (c) Age of husband or wife if alive 33 years

7. Birth date of deceased Nov. 27 1906 (Month) (Day) (Year)

8. AGE: Years 33 Months 10 Days 19 If less than one day hr. min.

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

10. Usual occupation Miner (coal)

11. Industry or business

12. Name Alex Chadwick
13. Birthplace mo.
14. Maiden name Jones
15. Birthplace mo.

16. (a) Informant Bill Clark (b) Address Lurona mo

17. (a) Burial (b) Date thereof Oct-19-40 (c) Place: burial or cremation

18. (a) Signature of funeral director (b) Address Unionville mo

19. (a) October 22 (b) Mamie Martin (c) Registrar's signature

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 16th year 1940 hour Six minute 30 P.M.

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

Immediate cause of death Cerebro spinal meningitis

Due to Do not know 2 weeks

Due to

Other conditions no (Include pregnancy within 3 months of death)

Major findings: Of operations no

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?

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

23. Signature E.H. Magee (M. D. or other) M.D.
Address Unionville Mo Date signed Oct 19-40

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

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

MOTHER FATHER

RECEIVED

District Health Officer No. 10

District File Number 11-40-2059

Date Filed NOV 8 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

Muel E. Husted

Licensed Embalmer No. 3304

P. O. Address Unmoullé m

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.