

Registration District No. 668

Primary Registration District No. 9032

1. PLACE OF DEATH:

(a) County Pettis

(b) City or town Sedalia  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1000 West 4th St.  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 26 years (Specify whether years, months or days)

In this community 26 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Pettis

(c) City or town Sedalia  
(If outside city or town limits, write "RURAL")

(d) Street No. 1000 West 4th St.  
(If rural, give location)

(e) If foreign born, how long in U. S. A. 0 years.

3. (a) PRINT FULL NAME Robert DeLoss Chisman

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

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

(b) Name of husband or wife Matilda Pitsnogle Chisman 6. (c) Age of husband or wife if alive years

7. Birth date of deceased August 12 1856  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 6 year 1940 hour 1 minute 10 M.

21. I hereby certify that I attended the deceased from Dec 3 to Dec 6 1940  
that I last saw him alive on Dec 3 1940  
and that death occurred on the date and hour stated above.

8. AGE: Years 84 Months 3 Days 4 If less than one day hr. min.

Immediate cause of death Cerebral Vascular Disease

Due to \_\_\_\_\_

Due to 12/1

Other conditions \_\_\_\_\_  
(include pregnancy within 3 months of death)

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

10. Usual occupation Not Employed

11. Industry or business \_\_\_\_\_

12. Name Thomas L. Chisman

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

14. Maiden name Unkown

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

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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

16. (a) Informant Mrs. M. E. Gouge

(b) Address Sedalia, Mo.

17. (a) Burial (b) Date thereof Dec. 8/40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Windsor, Mo.

18. (a) Signature of funeral director Gillespie Funeral Home  
Sedalia

(b) Address \_\_\_\_\_

19. (a) 12/7/40 (b) Mrs. Harry Sneed  
(Date received local registrar) (Registrar's signature)

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? 906  
(Specify type of place)

While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature Mrs. Bettyman (M. D. or other) 1  
Address Sedalia Mo Date signed 12/2/40

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

10  
4  
4

RECEIVED  
District Health Officer No. 8,  
District File Number  
Date Filed 1-14-41

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 L. E. Bowler  
Licensed Embalmer No. 3867  
P. O. Address Sedalia Mo

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, fact should be so stated above.