

FILLED NOV 14 1941

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 35953

Registration District No. 773

Primary Registration District No. 6018A

Registrar's No. 152

1. PLACE OF DEATH:

(a) County St. Francois  
(b) City or town Waynes, Tenn.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
State Hospital No. 4 S.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1 month, 20 days  
(Specify whether  
In this community \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Wayne  
(c) City or town Greenville  
(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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 23rd  
year 1941 hour 12 minute Noon M.

21. I hereby certify that I attended the deceased from 10-5, 19 41 to 10-23, 19 41;  
that I last saw h. im alive on 10-23-41, 19 41;  
and that death occurred on the date and hour stated above.

Immediate cause of death Broncho pneumonia, terminal Duration 1 day  
Due to Anterolobrosis, generalized and marked ?  
Due to \_\_\_\_\_

Other conditions Severe Bronchitis, Simple 2 years?  
(Include pregnancy within 3 months of death)  
Deterioration

Major findings:  
Of operations No operations  
Of autopsy No autopsy  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

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 C. C. Ault (M. D. or other) M.D.  
Address Farmington Date signed 10/27/41

3. (a) PRINT FULL NAME ALBERT B. CHANCE

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

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

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

7. Birth date of deceased June 7th 1863  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
78 4 16 \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Unknown

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

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant State Hospital No. 4 Record

(b) Address Farmington, Missouri

17. (a) Burial (b) Date thereof 10-24-41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation State Hospital Cemetery

18. (a) Signature of funeral director Neidert Funeral Home  
Farmington, Missouri

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

19. (a) Oct 24 41 (b) B. J. Robinson  
(Date received local registrar) (Registrar's signature)

(Licensed Embalmer's Statement on Reverse Side)

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

94  
0  
0

697

**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.....

*my*

....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

*John A. ...*

Licensed Embalmer No. *2238*

P. O. Address *Farmington*

**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.**