

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED FEB 11 1942

Registration District No. 237

Primary Registration District No. 4144

Registrar's No. 1

1. PLACE OF DEATH:

(a) County Dade Creston Township
(b) City or town Greenfield, Mo
(Outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 10 years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dade
(c) City or town Greenfield, Mo
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location) D
(e) If foreign born, how long in U. S. A. _____ years

3. (a) PRINT FULL NAME CYNTHA ANN CHISM
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Jan day 10
year 1942 hour 6 minute A. M.
21. I hereby certify that I attended the deceased from Nov. 10
1938, to Jan. 10, 1942
that I last saw her alive on Jan. 9, 1942
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife hus. Wm. Chism 6. (c) Age of husband or wife if alive 47 years
7. Birth date of deceased Nov. 18, 1866
(Month) (Day) (Year)

Immediate cause of death Pneumonia, Sobar
Due to _____
Due to _____
Other conditions Apoplexy, hemorrhage, cerebral 11/7/39
(Include pregnancy within 3 months of death)

8. AGE: Years Months Days If less than one day
75 1 23 hr. _____ min.

Duration 1/4/42
PHYSICIAN _____
Underline the cause to which death should be charged statistically

9. Birthplace Cedar Co. Missouri
(City, town, or county) (State or foreign country)
10. Usual occupation House wife

11. Industry or business _____
MOTHER FATHER { 12. Name Alfred Underwood
13. Birthplace Not known
(City, town, or county) (State or foreign country)
14. Maiden name Eliza White
15. Birthplace Kennesaw, Ga
(City, town, or county) (State or foreign country)

Major findings: Of operations 108
Of autopsy _____

16. (a) Informant's own signature P. R. Chism
(b) Address Fair play mo.
17. (a) Burial (b) Date thereof Jan. 12, 42
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Ludley Prairie Cem
18. (a) Signature of funeral director F. W. Wiser
(b) Address Greenfield, Mo
19. (a) _____ (b) _____
(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? _____
While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature J. S. Shannon (M. D. or other) D.O.
Address Greenfield, Mo Date signed 1/12/42

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

Rev. 5-17-39
1 X 111

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. 6,

District File Number 242-194

Date Filed FEB 10 1942

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.....

Bill L Lack

Registered Apprentice No. 305

working under my personal supervision.

Signed.....

J. W. Ward

Licensed Embalmer No. 2832

P. O. Address Greenfield, 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, above space should be left blank.

Registration District No. 237

Primary Registration District No. 4144

Registrar's No.

1. PLACE OF DEATH:

(a) County Madison
(b) City or town Greenfield
(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)

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 _____)

3. (a) PRINT FULL NAME Cynthia A. Chism
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Jan Day _____ Year 1942 Hour _____ Minute _____ M.
21. I hereby certify that I attended the deceased from _____ 19____;
that I first saw him/her alive on _____ 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

4. Sex F 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 Nov 18 1902
(Month) (Day) (Year)

Duration _____
Due to _____
Due to _____
Other conditions (include pregnancy within 9 months of death) _____
Major findings:
Of operations _____
Of autopsy _____

8. AGE: Years 75 Months 1 Days 10 If less than one day _____ 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) Jan 14-42 (b) Phyllis Lack
(Date received local registrar) (Registrar's signature)

Due to _____

Due to _____

Other conditions (include pregnancy within 9 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?
_____ (Specify type of place)

While at work? _____ (e) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

MOTHER FATHER

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

