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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAY 15 1943
300

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

15180

State File No. _____
Registrar's No. _____

Registration District No. 300 Primary Registration District No. 6029

1. PLACE OF DEATH:
(a) County Reynolds
(b) City or town Rural
(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 Life years, months or days

2. USUAL RESIDENCE OF DECEASED: 90
(a) State MO. (b) County Reynolds
(c) City or town Rural
(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 Polly Chitwood Chilton
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month April day 21 year 1943 hour 10 minute 30 p. M.
21. I hereby certify that I attended the deceased from March 11 1943 to April 21 1943
that I last saw her alive on March 11 1943 and that death occurred on the date and hour stated above.

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife Thomas Chilton 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Oct. 14 1873
(Month) (Day) (Year)

Immediate cause of death _____
Due to Staphylococcus infections to her foot
Due to lacerated injury
Other conditions (Include pregnancy within 3 months of death) _____
Duration _____

8. AGE: Years 69 Months 6 Days 7 If less than one day _____ hr. _____ min.
9. Birthplace Reynolds Co. Mo.
(City, town, or county) (State or foreign country)

PHYSICIAN _____
Underline the cause to which death should be charged statistically.
Major findings: Of operations _____
Of autopsy _____

10. Usual occupation Housewife
11. Industry or business _____
12. Name Johnathan Chitwood
13. Birthplace Tenn.
(City, town, or county) (State or foreign country)
14. Maiden name Argosy Williams
15. Birthplace Tenn.
(City, town, or county) (State or foreign country)

16. (a) Informant Sidney Speers
(b) Address Ellington
17. (a) Burial (b) Date thereof 4-24-43
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Pumpkin Hollow

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 _____

18. (a) Signature of funeral director Leuckel Funeral Serv
(b) Address Ellington Mo.
19. (a) 4/30-43 (b) Eddie Lovens
(Date received local registrar) (Registrar's signature)

23. Signature A. J. Burg (M. D. or other)
Address Ellington Mo. Date signed 4/21-43

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

1130

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 5,

District File Number 643316

Date Filed 5-12-42

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 4-22-4

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

Signed Philip A. Leubke
Licensed Embalmer No. 2936
P. O. Address Van Buren 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 15-180

Registration District No. 300

Primary Registration District No. 6029

Registrar's No.

1. PLACE OF DEATH:

(a) County Raymond

(b) City or town Rural
(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

3. (a) PRINT FULL NAME Pally e Chilton

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex 7 5. Color or race W

6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Oct 14 - 1872
(Month) (Day) (Year)

8. AGE: Years 69 Months 6 Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry of 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) _____ (b) _____
(Date received local registrar) (Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov Day 21 year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I have seen him _____ live on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____

Septicemic infection on all injury to foot. Due to injury acquired many years ago and recurrent at intervals. I signed my opinion on conditions presented and former history

Other conditions _____ (Include pregnancy within 3 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? _____

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

23. Signature A. F. Bugg (M. D. or other)
Address Callington, Mo Date signed _____

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

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

MOTHER FATHER

A. F. BUGG

S-15180