

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

LED JUL 9 1943

Registration District No. 764

Primary Registration District No. 3023

Registrar's No. 58

1. PLACE OF DEATH:

(a) County Johnson

(b) City or town Warrensburg

(c) Name of hospital or institution: Warrensburg Clinic  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 hours  
(Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Johnson

(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? no (Yes or No) 0  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Sandra Kay Chaney

3. (b) If veteran, name war no

3. (c) Social Security No. none

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 7  
year 1943 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased June 7 1943  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death Intracranial Hemorrhage

8. AGE:

Years	Months	Days	If less than one day
<u>0</u>	<u>0</u>	<u>0</u>	<u>3 hours</u>
			hr. min.

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

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

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

10. Usual occupation none

11. Industry or business none

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

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

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

MOTHER FATHER

12. Name Virgil Chaney

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

14. Maiden name Betty Swindell

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

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant Virgil Chaney

(b) Address Holden, Mo.

17. (a) Burial (Burial, cremation, or removal)

(b) Date thereof June 8, 1943  
(Month) (Day) (Year)

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

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

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? \_\_\_\_\_

18. (a) Signature of funeral director Sweeney Phillips

(b) Address Warrensburg, MO

19. (a) June 8, 1943 (Date received local registrar)

(b) Leola M. Williams (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place)

(c) Means of injury \_\_\_\_\_

23. Signature Kelly Rowland (M. D. or other) \_\_\_\_\_

Address Holden, Mo Date signed 6/9/43

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

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed 7-8-43

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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 *E. Ray Swerney*.....

Licensed Embalmer No. *1121*.....

P. O. Address *Warensburg*.....

**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.