

S. No. 2
OM-142
Rev. 5-17-39
I. X327

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28202

AUG 23 1943

State File No. _____
Registrar's No. 612A

Registration District No. 123

Primary Registration District No. 2000

1. PLACE OF DEATH: GREENE

(a) County: GREENE

(b) City or town: Springfield

(c) Name of hospital or institution: 2140 N. Franklin
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 7 days (Specify whether)

In this community 40 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Greene

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

(d) Street No.: 2140 N. Franklin (If rural, give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country: _____

3. (a) PRINT FULL NAME: Celia R. Chittenden

3. (b) If veteran, name war: None 3. (c) Social Security No.: None

4. Sex: Female 5. Color or race: White 6. (a) Single, widowed, married, divorced: Married

6. (b) Name of husband or wife: Horace P. Chittenden 6. (c) Age of husband or wife if alive: Deceased

7. Birth date of deceased: October 20, 1877 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	65	9	10	hr. min.

9. Birthplace: Schofield, Missouri (City, town, or county) (State or foreign country)

10. Usual occupation: Housewife

11. Industry or business: In Home

12. Name: John W. Oglesby

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

14. Maiden name: Mary Ellen Ross

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

16. (a) Informant: Mrs. R. L. Sullens

(b) Address: Webb City, Missouri

17. (a) Burial (Burial, cremation, or removal): Green Lawn Cemetery (c) Place: burial or cremation

18. (a) Signature of funeral director: Alma Lohmeyer Funeral Home (b) Address: Springfield, Missouri

19. (a) 8-6-43. (b) S. W. G. Handley (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: July day: 30, year: 1943 hour: 1:00 minute: A. M.

21. I hereby certify that I attended the deceased from 7/18 1943 to 7/30 1943; that I last saw her alive on 7/29/43 and that death occurred on the date and hour stated above.

Immediate cause of death: Hypertensive myocarditis

Due to: 9/30

Other conditions (Include pregnancy within months of death): Chronic Asthma

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) (e) Means of injury:

23. Signature: M. D. Smith (M. D. or other) Date signed: 7/6/43

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

MOTHER FATHER

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 *Ed. H. McKee*

Licensed Embalmer No. 1767

P. O. Address *Springfield*

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.