

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

31107

State File No. ....

Registrar's No. 1004

FILED SEP 24 1943  
Registration District No. 1000

Primary Registration District No. 1000

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

1. PLACE OF DEATH:

(a) County Buchanan  
(b) City or town St. Joseph  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
State Hospital #2  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether)  
In this community 30 years 15 days  
years, months or days

3. (a) PRINT FULL NAME Howard Chronister

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

4. Sex Male 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 \_\_\_\_\_ 1881  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
62 - - - hr. min.

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

10. Usual occupation Farmer

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

MOTHER FATHER { 12. Name Unknown  
13. Birthplace Unknown 9  
(City, town, or county) (State or foreign country)  
14. Maiden name Unknown  
15. Birthplace Unknown 9  
(City, town, or county) (State or foreign country)

16. (a) Informant Records, State Hosp. #2  
(b) Address Saint Joseph, Mo.

17. (a) B. (Burial, cremation, or removal) (b) Date thereof 9-12-1943  
(Month) (Day) (Year)

(c) Place: burial or cremation Savannah Mo

18. (a) Signature of funeral director E. C. Breit

(b) Address Savannah Mo

19. (a) 9-12-43 (b) Rose Hlegoy  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Andrew  
(c) City or town Helena  
(If outside city or town limits, write "RURAL")  
(d) Street No. Rural (If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 8  
year 1943 hour 3:30 minute A M.

21. I hereby certify that I attended the deceased from August 1, 1943, to September 8, 1943  
that I last saw him alive on September 7, 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis  
Chiliclysis & Carditis

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

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)  
Means of injury \_\_\_\_\_  
23. Signature P. B. T. Sweeney M.D. or other \_\_\_\_\_  
Address State Hosp. #2 Date signed 9-8-43

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

1233

(Licensed Embalmer's Statement on Reverse Side)

St. Joseph, Mo.

**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. C. Breth

Licensed Embalmer No. 2650

P.O. Address Sacramento

**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.**