

No. 2
-9-4-41
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **32187**

Registration District No. **67/248**

Primary Registration District No. **4-3-65 4369**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **Newton**

(b) City or town **Seneca**
(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 **Missouri** (b) County **Jasper**

(c) City or town **Joplin**
(If outside city or town limits, write "RURAL")

(d) Street No. **910 Kentucky**
(If rural, give location)

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

3. (a) PRINT FULL NAME **Dorothy Ann Chasteen**

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

4. Sex **Female** 5. Color or race **white**

6. (a) Single, widowed, married, divorced **0**

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

7. Birth date of deceased **May 31 1943**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

2 25 hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name **Robert Chasteen**

13. Birthplace **Missouri**
(City, town, or county) (State or foreign country)

14. Maiden name **Ruby Edison**

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

16. (a) Informant **Ruby Chasteen**

(b) Address **910 Ky Joplin, Mo.**

17. (a) removal _____ (b) Date thereof **Aug 26 1943**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Wyanotte Okla**

18. (a) Signature of funeral director **W. C. Chase**

(b) Address **Seneca Mo**

19. (a) **Sept. 10 - 1943** (b) **(Mrs) Nettie Norris**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug** day **25**
year **1943** hour **6:30** minute _____ P. M.

21. I hereby certify that I attended the deceased from **Aug 24** 19**43** to **Aug 25** 19**43**
that I last saw **her** alive on **Aug 24** 19**43** and that death occurred on the date and hour stated above.

Immediate cause of death **Dysentery bacillary**

Duration **6 days**

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) **27c**

Major findings: Of operations _____

Of autopsy _____

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

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 **John B. Roberts** (M. D. or other) **D.O.**

Address **P.O. Box 294** Date signed **7-26-43**
Seneca Mo.

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

MOTHER FATHER

1352

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. *10-5-43*

District File Number *1043-185*

Late Filed *10-8-43*

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.....

Licensed Embalmer No.....

P. O. Address.....

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.