

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

10-4-41
17-39
X29484

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

3820E
960

State File No.

Registrar's No.

FILED DEC 11 1943

Registration District No. 128

Primary Registration District No. 2000

1. PLACE OF DEATH:

(a) County GREENE
(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
O'Reilly General Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 months, 28 days
In this community 2 months, 28 days
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Ohio (b) County Knox
(c) City or town Rural, Mt. Vernon
(If outside city or town limits, write "RURAL")
(d) Street No. R.F.D. #5, Mt. Vernon, Ohio
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country 2

3. (a) PRINT FULL NAME Charles R. Chase

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

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife none
6. (c) Age of husband or wife if alive KK years
7. Birth date of deceased January 22 1909
(Month) (Day) (Year)

8. AGE: Years 34 Months 10 Days 6
If less than one day hr. min.

9. Birthplace Knox County Ohio
(City, town, or county) (State or foreign country)

10. Usual occupation Farming

11. Industry or business Unknown

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant W.D., A.G.O. Form 24

(b) Address O'Reilly Gen. Hosp.

17. (a) Removal (b) Date thereof Nov 30, 1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Centertburg, Ohio

18. (a) Signature of funeral director Therman Kahmeyer

(b) Address Springfield mo

19. (a) 11-29-43 (b) B. W. Handley
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 28
year 1943 hour 6 minute 02 A.M.

21. I hereby certify that I attended the deceased from September 1, 1943 to November 28, 1943
that I last saw him alive on November 28, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Uremia

Due to Intestinal obstruction, chronic

Due to

Other conditions Fracture, compound, comminuted, complete, tibia, left

Major findings: Of operations

of autopsy Confirmation of above diagnoses

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

(a) Accident, suicide, or homicide (specify) ✓

(b) Date of occurrence 136

(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 C. Caputo (M.D. or other)

Address O'Reilly General Hosp. Date signed 11-29-43

Duration 24 hrs

6 months

PHYSICIAN

Underline the cause to which death should be charged statistically.

984

(Licensed Embalmer's Statement on Reverse Side)

W

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.....

Walter E. Hamille

Licensed Embalmer No. *3808*

P. O. Address *Augusta, Ga.*

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 22cc

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH:

(a) County Greene
(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: O'Reilly Gen. Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 mo. 28 da.
In this community 2 mo. 28 da. (Specify whether years, months or days)

3. (a) PRINT FULL NAME Charles R. Chase

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

4. Sex m 5. Color or race W 6. (a) Single, widowed, married, divorced S

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

7. Birth date of deceased Jan. 22 - 1910
(Month) (Day) (Year)

8. AGE: Years 34 Months 10 Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or 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 28
Year 1943 Hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death Uremia

Intestinal obstruction
Due to Chronic
fracture. Compound
Due to Committuted. Complete
tibia left.

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of autopsy Done 9/9

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

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

(b) Date of occurrence 19 July 1943

(c) Where did injury occur? New Georgia, S.W. Pacific
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? battlefield

While at work? no (Specify type of place) (e) Means of injury blast injury from mortar shell

23. Signature J. L. Carpenter, Major, U.S.A. (M. D. or other) J. L.
Address O'Reilly General Hosp. Date signed 11-17-43

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

SUPPLEMENTARY

MOTHER FATHER

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

38208