

21980

S. No. 2
M-2-43
5-17-39

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUL 13 1944

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 200

Primary Registration District No. 5725

Registrar's No. 55

1. PLACE OF DEATH:

(a) County Macou

(b) City or town Macou, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Still-Hildreth Osteopathic San.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution. Seven yrs.
(Specify whether years, months or days)

In this community 0
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Macou ⁶¹

(c) City or town Macou, Mo. ³
(If outside city or town limits, write "RURAL") ²

(d) Street No. _____
(If rural, give location)

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

3. (a) PRINT FULL NAME Alfred B. Chrisman

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex male ⁰ 5. Color or race white

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

6. (b) Name of husband or wife Ida & Chrisman

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

7. Birth date of deceased Oct 1 1867
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>76</u>	<u>8</u>	<u>3</u>	hr. min.

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

10. Usual occupation Banker

11. Industry or business _____

12. Name Joseph Chrisman

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

14. Maiden name Mary

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

16. (a) Informant Ida & Chrisman

(b) Address 203 Clinton Place - R.C. Mo

17. (a) burial (b) Date thereof June 6 - 44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Starrantsville Mo

18. (a) Signature of funeral director Robert Sklar

(b) Address Macou Mo

19. (a) 6/30/44 (b) Mara B. Hunkler
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 4
year 1944 hour 3 minute 45 P.M.

21. I hereby certify that I attended the deceased from Nov. 5
_____, 1937, to June 4, 1944
that I last saw him alive on June 4, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Arterio-sclerosis ^{8 years}
Duration

Due to _____

Due to _____

Other conditions Hemiplegia ^{7 years}
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings: _____
Of operations _____
Of autopsy _____

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 Al Doyle D.O. (M. D. or other) ³
Address Macou Mo Date signed 6/5/44

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

1
3
2

RECEIVED

District Health Officer No. 10

District File Number 7-44-1277

Date Filed JUL 11 1944

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 Carlland Minor

Licensed Embalmer No. 3414

P. O. Address Mason M

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. July
Registrar's No. 55

Registration District No. 200

Primary Registration District No. 5725

1. PLACE OF DEATH:

(a) County Macon Rural
(b) City or town Macon Rural
(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)

3. (a) PRINT FULL NAME Alfred & Christina
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 M
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Oct 1 1900
(Month) (Day) (Year)

8. AGE: Years 76 Months 8 Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

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 July Year 1944 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

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

Major findings: Of operations _____
Of autopsy _____

Duration _____
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) (c) Means of injury _____

23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

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

SUPPLEMENTARY

21980