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THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **24889**

FILED AUG 15 1944

Registration District No. **136**

Primary Registration District No. **2001**

Registrar's No. **378**

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

**1. PLACE OF DEATH:**

(a) County Jasper

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

(c) Name of hospital or institution: St. Johns  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 10 weeks  
(Specify whether all life)

In this community all life  
years, months or days

**3. (a) PRINT FULL NAME** Lewis Franklin Chidress

**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** married

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

**7. Birth date of deceased** 11 / 1 / 1875  
(Month) (Day) (Year)

**8. AGE:**

Years	Months	Days	If less than one day
<u>69</u>	<u>9</u>	<u>8</u>	<u>0</u> hr. <u>                    </u> min.

**9. Birthplace** Galena Kansas  
(City, town, or county) (State or foreign country)

**10. Usual occupation**                     

**11. Industry or business** Mine operator

**12. Name** Wm Chidress

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

**14. Maiden name** Melvinia Westlake

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

**16. (a) Informant** Paul Chidress

**(b) Address** 508 Sergeant Joplin Mo

**17. (a) Burial**                      **(b) Date thereof** 8/3/44  
(Burial, cremation, or removal) (Month) (Day) (Year)

**(c) Place: burial or cremation** Mr. Hoff's Green

**18. (a) Signature of funeral director** Franklin Dillon

**(b) Address** Joplin Mo

**19. (a) 8-5-44** **(b) Gladys S. Slaughter**  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Jasper **49**

(c) City or town Joplin **3**  
(If outside city or town limits, write "RURAL")

(d) Street No. 307 Sergeant  
(If rural, give location)

(e) Citizen of foreign country?                      (Yes or No)

If yes, name country                     

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH:** Month Aug day 1 year 1944 hour 19 minute 129 M.

**21. I hereby certify that I attended the deceased from** 10 43 August 1 1944  
19... to ... 19...

that I last saw him alive on August 1 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Sclerosis **Duration** 1 year

Due to                     

Due to                     

Other conditions                       
(Include pregnancy within 3 months of death)

Major findings:                      **PHYSICIAN**                     

Of operations                                          

Of autopsy                     

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

**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**                      (M. D. or other)                     

**Address** Hoplin No. **Date signed** 8/2/44

44-7-647

JAN 10 1947

JAN 10 1947

JUN 6 1950

AUG 16 1944

SEP 23 1949

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 Cecil A. Harshill

Licensed Embalmer No. 3590

P. O. Address Joplin Mo.

**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. 24889

Registration District No. 156

Primary Registration District No. 2001

Registrar's No. 378

1. PLACE OF DEATH:

(a) County Jasper  
 (b) City or town Jasper  
(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 Lewis F. Childress

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 Nov \_\_\_\_\_  
(Month) (Day) (Year)

8. AGE: Years 69 Months 8 Days \_\_\_\_\_  
If less than one day \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_  
(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 \_\_\_\_\_ day \_\_\_\_\_  
 year 1944 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_, and that death occurred on the date and hour stated above.  
 Immediate cause of death \_\_\_\_\_

Due to Arteriosclerosis  
 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 a \_\_\_\_\_ (Specify type of case) \_\_\_\_\_  
 23. Signature \_\_\_\_\_ (M.D. or other) \_\_\_\_\_  
 Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTARY

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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

