

No. 2 / 5-43 17-39 X36871

State File No.

FILED DEC 14 1944
Registration District No. 345

Primary Registration District No. 6162

Registrar's No.

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

1. PLACE OF DEATH:

(a) County Stone

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

(c) Name of hospital or institution: Ruth Hosp
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 day (Specify whether years, months or days)

In this community 2 day

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Stone 114

(c) City or town Reeds Spring Mo
(If outside city or town limits, write "RURAL")

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

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

3. (a) PRINT FULL NAME LEXIE LOU CHASTINE

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

4. Sex 71 5. Color or race w 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 Nov 4 1944
(Month) (Day) (Year)

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

2 hr. — min.

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

10. Usual occupation none

11. Industry or business

MOTHER FATHER { 12. Name Arch Chastine

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

14. Maiden name Mary Morris

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

16. (a) Informant Arch Chastine

(b) Address Reeds Spring Mo

17. (a) Occidental Cem (b) Date thereof 11/17/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Occidental Cem

18. (a) Signature of funeral director J. W. Felder (acting)

(b) Address Reeds Spring Mo

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 6
year 1944 hour 2 minute 30 A M.

21. I hereby certify that I attended the deceased from Nov 6/44
to Nov 6, 1944
that I last saw her alive on Nov 6, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Indigestion

Duration 5 hrs

Due to 118:3

Due to 118:3

Other conditions (Include pregnancy within 3 months of death)

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 L. S. Spurgeon (M. D. or other) MD

Address Reeds Spring Date signed Nov 11/6/44

1355

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.

Registration District No. 345

Primary Registration District No. 6162

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Stam.

(b) City or town Reeds Springs, Ruthsburg
(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 Lexillon Chastine

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex F

5. Color or race W

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased mm.
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ (Unless than one day)

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) Dec-17-1944 (b) Grace White
(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
year 1944 hour _____ minute _____ M.

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

Duration _____

Due to _____

Due to _____

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

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

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

MOTHER FATHER

SUPPLEMENTARY

38999

Rock Springs
Wyo.

Wm. H. H. H. H.