. S. No. 2
00M—2-43
ev. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 4 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 42266

Registration District No. 381

Primary Registration District No. 4515 —

Registrar's No.

1. PLACE OF DEATH:
(a) County Sullivan
(b) City or town Milan
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Simpson Hospt
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 hrs (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Sullivan
(c) City or town Milan
(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

3. (a) PRINT FULL NAME Sue Cheyney
3. (b) If veteran, name war —
3. (c) Social Security No. —
4. Sex Fml
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 Nov. (Month) 25 (Day) '44 (Year)
8. AGE: Years | Months | Days | If less than one day 3 hr. 15 min.
9. Birthplace Milan (City, town, or county) Mo (State or foreign country)
10. Usual occupation —
11. Industry or business —
MOTHER FATHER
12. Name Robert J Cheyney
13. Birthplace Milan (City, town, or county) Mo (State or foreign country)
14. Maiden name Lucy Belle Cheyney
15. Birthplace Newtown (City, town, or county) Mo (State or foreign country)
16. (a) Informant Robert Cheyney
(b) Address Milan Mo
17. (a) (Burial, cremation, or removal) (b) Date thereof 11/26/44 (Month) (Day) (Year)
(c) Place: burial or cremation Oakwood
18. (a) Signature of funeral director Schwem Funeral Dir.
(b) Address Milan Mo
19. (a) Dec 8 44 (Date received local registrar) (b) Mrs. L D Green (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 26 year 44 hour 15 minute A.M.
21. I hereby certify that I attended the deceased from Nov. 25, 1944, to Nov. 26, 1944, that I last saw her alive on Nov. 26, 1944, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Premature Birth	3 15 hrs.
Due to:	
Due to: 159	
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? (Specify type of place)
While at work? (e) Means of injury
23. Signature Eugene Simpson (M. D. or other) DO
Address Milan Date signed 12-2-44

1190 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 18
District File Number ~~1945-1~~ 1-45-1
Date Filed JAN 3 1945

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.