

S. No. 2
 DM-2-43
 v. 5-17-39
 9-1 X35897

DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS
FILED FEB 14 1945

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **2981**

Registration District No. **254**

Primary Registration District No. **4385**

Registrar's No. _____

1. PLACE OF DEATH:
 (a) County Oregon
 (b) City or town Koshkonong
(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) 1
 (d) Length of stay: In hospital or institution _____
(Specify whether
 In this community 4 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Oregon
 (c) City or town Koshkonong
(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 Joseph Edward Chastain
 3. (b) If veteran, name war --
 3. (c) Social Security No. ✓

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Dec. day 31
 year 1944 hour 8 minute 00 P. 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.

4. Sex Male 5. Color or race White
 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Florence Campbell
 6. (c) Age of husband or wife if alive 58 years
 7. Birth date of deceased Feb. 24 1384
(Month) (Day) (Year)

Immediate cause of death Cerebral hemorrhage
 Duration Dec 31 1944

8. AGE: Years 60 Months 10 Days 7
 If less than one day hr. _____ min. _____

Due to Hypertension 1937
 Due to Chronic nephritis 1937

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

Other conditions None
(Include pregnancy within 3 months of death)

10. Usual occupation Mail Handler

Major findings: Of operations _____

11. Industry or business K. C. Railway Terminal

Of autopsy _____
PHYSICIAN
 Underline the cause to which death should be charged statistically.

12. Name William Chastain

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

14. Maiden name Isophine Bridges

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

16. (a) Informant Mrs. J. E. Chastain
 (b) Address Koshkonong, Mo.

17. (a) Burial (b) Date thereof 1/3/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bridges Cem.
 18. (a) Signature of funeral director Res Parr
 (b) Address Thayer, Mo.
 19. (a) 1-15-45 (b) Jae Williams
(Data received local registrar) (Registrar's signature)

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 Thelma Blaine (M. D.)
 Address Man Spout Date signed 1-9-45

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

15000

RECEIVED

District Health Officer No. 5.

District File Number 243-78

Date Filed 2-12-45

FEB 16 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.