

FILED MAR 14 1945

Registration District No. 234

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 5816

State File No. 6724

Registrar's No. 3

1. PLACE OF DEATH:

(a) County Morgan
(b) City or town Rural Richland Twp.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(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 Susie Frances Chilcoat

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

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Wm. Chilcoat 6. (c) Age of husband or wife if alive 73 years
7. Birth date of deceased Aug. 19 1876
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
68 5 24 hr. min.

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

10. Usual occupation House wife

11. Industry or business _____

MOTHER FATHER
12. Name David Baughman
13. Birthplace Morgan County Mo.
(City, town, or county) (State or foreign country)
14. Maiden name Mary Catherine Jones
15. Birthplace Morgan County Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Wm. Chilcoat
(b) Address Florence, Mo.

17. (a) Burial (b) Date thereof Feb. 15, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Florence Cemetery

18. (a) Signature of funeral director J. J. Stevenson
(b) Address Stover, Mo.

19. (a) Feb. 14, 1945 (b) Henry T. [Signature]
(Date received local registrar) (Registrar's signature)

1030

(Licensed Embalmer's Statement on Reverse Side)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Morgan
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. 3 mi. west of Florence
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 13
year 1945 hour 7 minute A. M.

21. I hereby certify that I attended the deceased from 1-25-45
1945, to 2-13-45 1945;
that I last saw her alive on 2-11-45 1945;
and that death occurred on the date and hour stated above.

Immediate cause of death Lobar Pneumonia. Duration 3 da

Due to Uremia Duration unknown.

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 [Signature] (M. or other) 2-14-45
Address Stover, Mo. Date signed 2-14-45

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

RECEIVED

District Health Officer No. 70

District File Number 2-45-201

Date Filed 3-13-45

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.....

J. L. Stevenson

Licensed Embalmer No. 4073

P. O. Address *Stover 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. March
Registrar's No. 3

Registration District No. 234 Primary Registration District No. 5816

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

1. PLACE OF DEATH:

(a) County Morgan

(b) City or town Rural Richland Sup
(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 Lucile F. Chilcote

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 Aug 19 1906
(Month) (Day) (Year)

8. AGE: Years 68 Months 5 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 Day 23 Year 1945 hour _____ minute _____ M.

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

Due to Suppressed urine

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

1336

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) (e) Means of injury _____

23. Signature Dr. B. Reynolds (M. D. or other) DO
Address _____ Date signed 12-10-45

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