

FILED MAR 18 1945

Registration District No.

Primary Registration District No.

4168

Registrar's No.

16

1. PLACE OF DEATH:

(a) County DE KALB
(b) City or town MAYSVILLE
(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.
In this community LIFE (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County DE KALB
(c) City or town MAYSVILLE 32
(If outside city or town limits, write "RURAL") 2
(d) Street No. (If rural, give location) 0
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country.

3. (a) PRINT FULL NAME CLARENCE MELVIN CHANEY

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

4. Sex MO 5. Color or race W
6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife SALLIE CHANEY 6. (c) Age of husband or wife if alive 56 years

7. Birth date of deceased July 28 - 1883
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
61 6 24 hr. min.

9. Birthplace DE KALB CO. MO (City, town, or county) (State or foreign country)

10. Usual occupation HARNESS MAKER

11. Industry or business REPAIR SHOP

12. Name THOMAS CHANEY

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

14. Maiden name CHRISTINE BARBER

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

16. (a) Informant Sallie Chaney

(b) Address Maysville MO

17. (a) Burial (b) Date thereof 7-22-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place OSBORN MAYSVILLE MO

18. (a) Signature of funeral home WALSH FUNERAL HOME
(b) Address 717 S. WALKER MO

19. (a) 7/20/45 (b) John Clome
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month FEB day 19 year 1945 hour 8 minute 30 P.M.

21. I hereby certify that I attended the deceased from June 1943, to Feb 19 1945 that I last saw h.i.m. alive on Feb 19 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Apoplexy Duration 1 hour
Due to hypertension and chronic nephritis 59w

Due to
Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 1318
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 Dr. Harold Fowler (M. D. or other) 16
Address Maysville MO Date signed 7/20

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

0202

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. *3960*
P. O. Address..... *Maysville 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.