V. S. No. 2
50M—9-4-41
Rev. 5-17-39
I X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 10 1945

Registration District No. 47

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 12998

Primary Registration District No. 3008

Registrar's No. 119

1. PLACE OF DEATH:
(a) County Calloway
(b) City or town Fulton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: State Hosp. No 1 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 15 days (Specify whether
In this community 15 days years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County St. Louis
(c) City or town Robertson 14
(If outside city or town limits, write "RURAL")
(d) Street No. 1
(If rural, give location)
(e) Citizen of foreign country? no 2 (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME William R. Chase

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex male

5. Color or race colored 2

6. (a) Single, widowed, married, divorced married 1

6. (b) Name of husband or wife Majorie Ada Chase

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

7. Birth date of deceased Feb. (Month) 8 (Day) 1908 (Year)

8. AGE:

Years	Months	Days	If less than one day
37	1	26	hr. min.

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

10. Usual occupation Laborer

11. Industry or business

FATHER
12. Name James A Chase
13. Birthplace Daline (City, town, or county) Mo (State or foreign country)

MOTHER
14. Maiden name Ollie Poindexter
15. Birthplace Cooper (City, town, or county) Mo (State or foreign country)

16. (a) Informant Mrs W-R Chase
(b) Address Robertson Mo

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 4/6/1945 (Month) (Day) (Year)
(c) Place: burial or cremation Saint Louis Mo.

18. (a) Signature of funeral director Charles J Gates
(b) Address 4107 Finney Ave.

19. (a) 4-6-1945 (Date received local registrar) (b) Josie Morsinkhoff (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month ~~March~~ April day 4
year 1945 hour 4 minute 10 P. M.

21. I hereby certify that I attended the deceased from March 19, 1945, to April 4, 1945; that I last saw him alive on April 4, 1945; and that death occurred on the date and hour stated above.

Immediate cause of death Lobar Pneumonia

Due to Syphilitic meningo encephalitis

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy 30 b

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?
(Specify type of place)
While at work? (e) Means of injury

23. Signature Forrest Thomas (M. D. or other)
Address Fulton Mo State Hosp No 1 Date signed 4/4/45

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9,

District File Number.....

Date Filed 5-9-45

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 Thomas Peter

Licensed Embalmer No. 4259

P. O. Address 4107 Farmington

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.