

S. No. 2
M-5-42
5-17-39
X32873

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

16396

State File No.

FILED MAY 28 1945
Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 401

1. PLACE OF DEATH:
(a) County **GREENE**
(b) City or town **Springfield**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **1113 Texas**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
In this community.....
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Greene**
(c) City or town **Springfield**
(If outside city or town limits, write "RURAL.")
(d) Street No. **1113 Texas**
(If rural, give location)
(e) Citizen of foreign country?.....
If yes, name country.....

3. (a) PRINT FULL NAME **Mazelle Chenault**
3. (b) If veteran, name war **NONE**
3. (c) Social Security No. **NONE**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **May** day **14** year **1945** hour **1** minute **20 P.** M.

4. Sex **Female** 5. Color or race **Col.** 6. (a) Single, widowed, married, divorced **Widow**
6. (b) Name of husband or wife **UNK.** 6. (c) Age of husband or wife if alive **Dec.** years
7. Birth date of deceased **UNK. UNK. 1890**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **Apr. 1-45** to **May 11-45**
that I last saw her alive on **May 11-45** and that death occurred on the date and hour stated above.
Immediate cause of death **Chr. Hypertensive cardio-vascular disease**
Duration **1 yr?**

8. AGE: Years **55** Months **UNK.** Days **UNK.** If less than one day hr. min.

Due to.....
Due to.....

9. Birthplace **India** (City, town, or county) **India** (State or foreign country)

Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations.....
Of autopsy.....

10. Usual occupation **Housewife**
11. Industry or business.....
12. Name **Unknown**
13. Birthplace **UNK.** (City, town, or county) **UNK.** (State or foreign country)
14. Maiden name **UNK.**
15. Birthplace **UNK.** (City, town, or county) **UNK.** (State or foreign country)

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

16. (a) Informant **E. McFarland**
(b) Address **1113 Texas - Spfld, Mo.**
17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **18-1945** (Month) (Day) (Year)
(c) Place: burial or cremation **Lincoln Mem.**

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.....

18. (a) Signature of funeral director **W. P. Campbell**
(b) Address **867 Washington, Spfld, Mo.**
19. (a) **5-18-45** (Date received local registrar) (b) **W. P. Campbell** (Registrar's signature)

23. Signature **Arthur D. Knapp** M. D. or other **M.D.**
Address **450 1/2 E. Canal** Date signed **5-17-45**

(Licensed Embalmer's Statement on Reverse Side)

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

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..... *W. P. Campbell*
Licensed Embalmer No..... *1747*
P. O. Address..... *Springfield*

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.