

FILED SEP 2 1945
Registration District No. **324**

Primary Registration District No. **372**

Registrar's No. **117**

1. PLACE OF DEATH:

(a) County **Saline**
(b) City or town **Marshall**
(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 **All his life**
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Saline 97**
(c) City or town **Marshall 1**
(If outside city or town limits, write "RURAL")
West Boyd 2
(If rural, give location)
(e) Citizen of foreign country? **0** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Joseph Oliver Chaffee**

3. (b) If veteran, name war _____ 3. (c) Social Security No. **500-20-2240**

4. Sex **Male 0** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widowed?**
6. (b) Name of husband or wife **Ema Miller Chaffee** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **February 17th, 1878**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
67 5 15 hr. min.

9. Birthplace **Marshall Missouri 0**
(City, town, or county) (State or foreign country)

10. Usual occupation **Carpenter**

11. Industry or business _____

MOTHER FATHER

12. Name **Myron M. Chaffee**
13. Birthplace **New York 1**
(City, town, or county) (State or foreign country)
14. Maiden name **Harriett Rosenbury**
15. Birthplace **Ohio 1**
(City, town, or county) (State or foreign country)

16. (a) Informant **Charlie Chaffee**
(b) Address **Marshall, Missouri**
17. (a) **Burial** (b) Date thereof **Aug. 4, 1945**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Ridge Park cemetery**

18. (a) Signature of funeral director **Camille Linn**
(b) Address **Marshall, Mo.**
19. (a) **8-3-45** (b) **Mrs. Toubethor**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug** day **2**
year **1945** hour **11** minute **9** M.

21. I hereby certify that I attended the deceased from **Investigated Aug 1, 1945**
that I last saw him alive on _____, 19____
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Haemorrhage**

Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations **gpa**

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 **Saline Co.**
Signature **S. L. Lailless Currier** (M. D. or other)
Address **Marshall Mo.** Date signed **8-3-45**

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

77
1
2

1215

LIVED

District Health Officer No. 8,

District File Number.....

Date Filed 9-8-45

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 Jan. N. Dennis.....

Licensed Embalmer No. 1171.....

P. O. Address Marshall 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.