S. N
M—5-42
. 5-17-39
I X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

30937

State File No.

FILED SEP 21 1945

Registration District No. 176

Primary Registration District No. 5716

Registrar's No. 6

1. PLACE OF DEATH:

(a) County MCDonald Elkriver Twp

(b) City or town Noel Rural
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Noel /
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community 10, Yrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO, (b) County MCDonald 60

(c) City or town Noel Rural 0
(If outside city or town limits, write "RURAL")

(d) Street No. Noel MO, 0
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Mary Chaffin

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 Single 0

6. (b) Name of husband or wife

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

7. Birth date of deceased Sept, (Month) 13th, (Day) 1861 (Year)

8. AGE: Years	Months	Days	If less than one day
83	10	20	hr. min.

9. Birthplace Not known (City, town, or county) TENN, / (State or foreign country)

10. Usual occupation Housekeeper

11. Industry or business

FATHER
12. Name Francis M, Chaffin
13. Birthplace Not known (City, town, or county) TENN, / (State or foreign country)

MOTHER
14. Maiden name Sallie Loftis
15. Birthplace Not known (City, town, or county) TENN, / (State or foreign country)

16. (a) Informant MRS, Roy Bates,
(b) Address Noel MO,

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 8-4-1945 (Month) (Day) (Year)

(c) Place: burial ~~cremation~~ Moline Kansas

18. (a) Signature of funeral director Chas W. Williams
(b) Address Goodman MO,

19. (a) 8-4-45 (Date received local registrar) (b) Mrs E.M. George (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug, day 3
year 1945 hour 10 minute 30, A, M.

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

	Duration
Immediate cause of death ~~Hypostatic~~	
Due to Anemia	2 Wks
Due to Fracture of Hip	6 mos
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.

OPTIONAL SUPPLEMENTARY INFORMATION REQUESTED

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 S. B. Buck (M. D. or other)
Address Anderson, MO Date signed 8/4/45

1304

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 6
District File Number 945-959
Date Filed SEP 19 1945

[redacted]

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 B. W. Buzzard

Licensed Embalmer No. 2334

P. O. Address Seneca, 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.