S. No. 2
M—5-43
. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 42020

FILED JAN 4 1946

Registration District No. ____ Primary Registration District No. 5878 Registrar's No. ____

1. PLACE OF DEATH:
(a) County: Oregon
(b) City or town: Alton Woodwide Twsp.
(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)
(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days)
In this community: 50 years

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Oregon 75
(c) City or town: Alton (Rural)
(If outside city or town limits, write "RURAL") 0
(d) Street No. ____ 1
(If rural, give location)
(e) Citizen of foreign country? ____ (Yes or No) 0
If yes, name country ____

3. (a) PRINT FULL NAME: John William Chronister
3. (b) If veteran, name war: --
3. (c) Social Security No.: --
4. Sex: Male 0
5. Color or race: White
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: Mary Elizabeth Rhodebush
6. (c) Age of husband or wife if alive: 80 years
7. Birth date of deceased: Jan. (Month) 25 (Day) 1866 (Year)

8. AGE:

Years	Months	Days	If less than one day
79	10	6	____ hr. ____ min.

9. Birthplace: Texas County (City, town, or county) Missouri 0 (State or foreign country)
10. Usual occupation: Farmer
11. Industry or business: ____

FATHER
12. Name: John William Chronister
13. Birthplace: Unknown (City, town, or county) 9 (State or foreign country)

MOTHER
14. Maiden name: Sarah Ford
15. Birthplace: Unknown (City, town, or county) 9 (State or foreign country)

16. (a) Informant: J. L. Millsap
(b) Address: Alton, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 12/4/45 (Month) (Day) (Year)
(c) Place: burial or cremation: Hickory Grove Cem.
18. (a) Signature of funeral director: Leo Barr
(b) Address: Thayer, Mo.
19. (a) 12-12-45 (Date received local registrar) (b) Mrs W C Johnson (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Dec. day: 1
year: 1945 hour: 9 minute: 00 P. M.
21. I hereby certify that I attended the deceased from Aug ✓, 1945, to Dec 1, 1945; that I last saw him alive on Dec 1, 1945; and that death occurred on the date and hour stated above.

Immediate cause of death: Acute Myocarditis
Chronic Bronchitis
Due to: Senility
Due to: ____
Other conditions (Include pregnancy within 3 months of death): ____
Major findings: Of operations: ____
Of autopsy: ____

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: W Cooper MD (M. D. or other)
Address: Thayer Mo Date signed: 12-6-45

1484 (Licensed Embalmer's Statement on Reverse Side)

Cooper

RECEIVED

District Officer No. [illegible]

District File No. 14690

Date Filed 1-9-46

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.....

P. O. Address.....

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.

S. No. 2B
5M—3-45
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Jan

Registration District No. 255 Primary Registration District No. 5878 Registrar's No.

1. PLACE OF DEATH:

(a) County Oregon

(b) City or town Rural, woodside twp
(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)

(d) Length of stay: In hospital or institution (Specify whether

In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County

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

(d) Street No.
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME John W. Chronister

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased Jan 25, 1868
(Month) (Day) (Year)

8. AGE: Years 79 Months 10 Days 6 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace
(City, town, or county) (State or foreign country)

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

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) 1-14-46 (Date received local registrar) (b) Mrs W C Johnson (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month day year hour minute 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.

Immediate cause of death	Duration
Due to	
Due to	
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.

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 (M. D. or other)

Address Date signed

SUPPLEMENTARY

42020