

S. No. 2
4-8-43
5-17-39
PI X37923

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 6748

Registration District No. 286

Primary Registration District No. 59784424

Registrar's No.

1. PLACE OF DEATH:

(a) County Polk

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

(c) Name of hospital or institution: Geo. Hemmitt Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 week
(Specify whether years, months or days)

In this community 1 week
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Hickory 43

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

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

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

If yes, name country _____

3. (a) PRINT FULL NAME Derhl Max Chaney Jr.

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex male 5. Color or race white

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased Aug. 4 1945
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

0 6 6 hr. _____ min.

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

10. Usual occupation Infant

11. Industry or business _____

MOTHER FATHER

12. Name Derhl Chaney

13. Birthplace Hickory Co. Mo. (U)
(City, town, or county) (State or foreign country)

14. Maiden name Margaret Lips

15. Birthplace Hickory Co. Mo. (U)
(City, town, or county) (State or foreign country)

16. (a) Informant Derhl Chaney

(b) Address Pittsburg, Mo.

17. (a) Burial (b) Date thereof Feb. 13, 1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Antioch Cemetery
Antioch, Mo.

18. (a) Signature of funeral director _____

(b) Address Humansville, Mo.

19. (a) Feb. 11, 1946 (b) Luille Kirkpatrick
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 10
year 1946 hour 10 minute 10 A.M.

21. I hereby certify that I attended the deceased from 2/2, 1946 to 2/10, 1946
that I last saw him alive on 2/2, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral spinal meningitis
(Pneumococci)

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations 6

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? _____

While at work? _____ (Specify type of place)

(e) Means of injury U

23. Signature W.H. Robinson (M. D. or other) M.D.
Address Humansville, Mo. Date signed 2/4/46

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.....

by me....., Registered Apprentice No.....
working under my personal supervision.

Signed *E. H. Purnin*.....

Licensed Embalmer No. *4282*.....

P. O. Address *Humansville, 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.