

FILED AUG 20 1946

Registration District No.

Primary Registration District No. 5416

Registrar's No.

1. PLACE OF DEATH:

(a) County St. Genevieve
(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Osark Osteopathic Hospital
(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 Missouri (b) County Polk 84
(c) City or town Humansville (1)
(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 Chester Carl Eugene Storall

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. —
6. (b) Name of husband or wife. _____ 6. (c) Age of husband or wife if alive. _____ years
7. Birth date of deceased 8 9 1946
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days 9 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name Chester Carl Storall

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

14. Maiden name Arctyn Harveyne Chitwood

15. Birthplace Humansville Kansas
(City, town, or county) (State or foreign country)

16. (a) Informant Blanch Fleckner (Sister)
(b) Address Humansville Mo.

17. (a) Buried (b) Date thereof Aug 19 1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Humansville Austley

18. (a) Signature of funeral director _____
(b) Address Humansville Mo.

19. (a) _____ (b) Dr. W. E. Handley
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 day 18
year 1946 hour 8 minute 45 AM

21. I hereby certify that I attended the deceased from 8-9-46 to 8-18-46, 1946
that I last saw him alive on 8-17, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Gastric hemorrhage 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? _____ Means of injury _____

23. Signature R. A. Michael, D.O. (M. D. or other) _____
Address Springfield, Mo. Date signed 8-18-46

MOTHER FATHER

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.....

..... *No embalming*, Registered Apprentice No.....
working under my personal supervision. 

Signed..... *[Signature]*

Licensed Embalmer No. *4282*

P. O. Address *Humanville,*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

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13880

State File No. Sept
Registrar's No. _____

Registration District No. 128

Primary Registration District No. 5x66

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Springfield
(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 _____ (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 Chester C. E. Stoval

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 _____

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

7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

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

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____
13. Birthplace _____ (City, town, or county) _____ (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) D. W. Hardy
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept 18
year 1948 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____;

that I last saw him _____ 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? _____

While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

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

20911