

FILED OCT 4 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

29255

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 30 PRIMARY REG. DIST. NO. 4038 Registrar's No. 36

1. PLACE OF DEATH a. COUNTY <u>Benton</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Benton</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>WARSAW</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>WARSAW, MO</u>	
c. LENGTH OF STAY (in this place) <u>2 1/2 yrs.</u>		d. STREET ADDRESS (If rural, give location)	
d. FULL NAME OF HOSPITAL OR INSTITUTION			
3. NAME OF DECEASED a. (First) <u>Joseph</u>		b. (Middle) <u>William</u>	
c. (Last) <u>CHASTAIN</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Sept 22, 1949</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>Nov 25, 1879</u>
9. AGE (In years last birthday) <u>69</u>		10. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
11. BIRTHPLACE (State or foreign country) <u>Henry County</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13a. FATHER'S NAME <u>John Chastain</u>		13b. MOTHER'S MAIDEN NAME <u>Cordina Coon</u>	
14. NAME OF HUSBAND OR WIFE <u>Fanny K. Chastain</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT'S SIGNATURE OR NAME <u>Larry K. Chastain</u>		ADDRESS <u>Warsaw</u>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>hypertension</u>  DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR			
22. I hereby certify that I attended the deceased from <u>Sept., 17, 49</u> , to <u>Sept., 22, 1949</u> , that I last saw the deceased alive on <u>Sept., 22, 1949</u> , and that death occurred at <u>7:10</u> m., from the causes and on the date stated above.			
23a. SIGNATURE <u>W. S. D. O.</u>		23b. ADDRESS <u>Warsaw, Mo.</u>	
23c. DATE SIGNED <u>9/23/49</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>Sept 24, 1949</u>	
24c. NAME OF CEMETERY OR CREMATORY <u>Englewood Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Clinton, Mo</u>	
DATE REC'D BY LOCAL REG. <u>Sept 24 1949</u>		REGISTRAR'S SIGNATURE <u>Jas A. Logan</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Bean</u>		ADDRESS <u>Warsaw</u>	

RECEIVED

District Health Officer No. 7,

District File Number 9-49-1176

Date Filed 10-3-49

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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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed

*John I. Brier*

Licensed Embalmer No. 4098

P. O. Address Wassaw

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.