

FILED OCT 28 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33299

State File No.

BIRTH NO. _____ REG. DIST. NO. 71 PRIMARY REG. DIST. NO. 3012 Registrar's No. 114

1. PLACE OF DEATH a. COUNTY <u>Clay</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Clinton</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Excelsior Springs, Mo.</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Turney</u>	
c. LENGTH OF STAY (In this place) <u>16 days</u>		d. STREET ADDRESS (If rural, give location) <u>RR # 1</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION: <u>VA Hospital, Excelsior Springs, Missouri</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>William</u> b. (Middle) <u>--</u> c. (Last) <u>Chaney</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Oct. 13, 1949</u>		
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) <u>Divorced</u>	
8. DATE OF BIRTH <u>Jan. 8, 1896</u>			9. AGE (In years last birthday) <u>53</u>		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Cedar County, Missouri</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>					

13a. FATHER'S NAME <u>Charles Chaney</u>		13b. MOTHER'S MAIDEN NAME <u>Myrtle Rigdon</u>		14. NAME OF HUSBAND OR WIFE <u>--</u>	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes World War I</u>		16. SOCIAL SECURITY NO. <u>Not remembered</u>		17. INFORMANT'S SIGNATURE OR NAME <u>VA Hospital Records, Excelsior Springs, Mo</u>	
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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>Right hemiplegia & cerebral hemorrhage</u> ANTECEDENT CAUSES DUE TO (b) <u>Hypertensive vascular disease</u> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Pulmonary pathology, type undetermined.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>approx. 15da.</u> <u>331X</u> <u>Unknown</u>
19a. DATE OF OPERATION <u>--</u>		19b. MAJOR FINDINGS OF OPERATION <u>--</u>			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 Sept. 27, 1949, to Oct. 13, 1949, ~~that I attended the deceased~~ and that death occurred at 4:40 a. m., from the causes and on the date stated above.

22a. SIGNATURE <u>PAUL BRUCE M. D.</u>			23b. ADDRESS <u>Excelsior Springs, Mo.</u>			23c. DATE SIGNED <u>10-13-49</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE <u>10-15-1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Plattsburg</u>		24d. LOCATION (City, town, or county) (State) <u>Mo.</u>		
DATE REC'D BY LOCAL REG. <u>10/13/49</u>		REGISTRAR'S SIGNATURE <u>Caroline Hutchings</u>			25. FUNERAL DIRECTOR'S SIGNATURE <u>Hope Funeral Home</u>			ADDRESS <u>Excelsior Springs, Mo.</u>

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

RECEIVED OCT 27
District Health Officer No. 8,
District File Number _____
Date Filed 10-27-49

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 James A. Moles
Licensed Embalmer No. 3296
P. O. Address Ex-Springs N

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.