

FILED MAR 12 1951

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 4145

0220

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 67 PRIMARY REG. DIST. NO. 4118 Registrar's No. 6

1. PLACE OF DEATH a. COUNTY Christian Co		2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission). a. STATE Mo COUNTY Christian Co	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Sparta		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Sparta	
d. FULL NAME OF HOSPITAL OR INSTITUTION Sparta Mo		d. STREET ADDRESS (If rural, give location) Sparta Mo	
3. NAME OF DECEASED a. (First) Francis		b. (Middle) E	
		c. (Last) Chronnister	
4. DATE OF DEATH (Month) (Day) (Year) Mar 2 1951			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Mar. 13, 1872
9. AGE (In years last birthday) 78		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper	11. BIRTHPLACE (State or foreign country) Mo
		12. CITIZEN OF WHAT COUNTRY? U S A	
13a. FATHER'S NAME David Walker		13b. MOTHER'S MAIDEN NAME Sarah Shipman	
14. NAME OF HUSBAND OR WIFE Mrs Edith Bond		Sparta Mo	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. _____	
17. INFORMANT'S SIGNATURE OR NAME Mrs Edith Bond		ADDRESS Sparta Mo	
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) <i>Uremic Poisoning</i> ANTECEDENT CAUSES <i>Arterial Hypertension</i> DUE TO (b) <i>Arteriosclerosis</i> DUE TO (c) <i>Arteriosclerosis</i> 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"/>		334X	
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 Feb-18, 1951, to Mar-2, 1951, that I last saw the deceased alive on Feb-1, 1951, and that death occurred at 2 P. M., from the causes and on the date stated above.			
23a. SIGNATURE Dr. Warren H. Wilson		23b. ADDRESS Sparta, Mo.	
23c. DATE SIGNED Mar-7-51			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Mar. 4, 1951	24c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery	24d. LOCATION (City, town, or county) (State) Christian Mo
DATE REC'D BY LOCAL REG. Mar 7 51	REGISTRAR'S SIGNATURE Lillie Barr 58	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS T. B. Chaffin Ozark Mo	

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

DIVISION OF HEALTH OF MD.  
District No. 5 - Springfield

RECEIVED MAR 9 1951

Dist. File 331-506

Date Filed 3-9-51

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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 \_\_\_\_\_

working under my personal supervision.

Student Embalmer No. ....

Signed

T. B. Chaffin

Signed.....

Student Embalmer

Licensed Embalmer No. 2192

P. O. Address Ozark, 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.