

FILED JUN 18 1951

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **19859**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **128** PRIMARY REG. DIST. NO. **2000** Registrar's No. **523**

1396

1. PLACE OF DEATH a. COUNTY <b>GREENE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Greene</b>	
b. CITY (If outside corporate limits, write RURAL and give township) <b>Springfield</b>	c. LENGTH OF STAY (In this place)	c. CITY (If outside corporate limits, write RURAL and give township) <b>Springfield</b>	<b>1396</b>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Springfield Baptist Hospital</b>		d. STREET ADDRESS (If rural, give location) <b>2415 N. Howard</b>	<b>0</b>

3. NAME OF DECEASED (Type or Print) a. (First) <b>ZILPHA</b>	b. (Middle)	c. (Last) <b>CHASTAIN</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>6-11-51</b>
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>June 22, 1892</b>	9. AGE (In years last birthday) <b>58</b>	10 UNDER 1 YEAR Months Days	10 OVER 1 YEAR Hours Mins.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>In Home</b>	11. BIRTHPLACE (State or foreign country) <b>Bessermen Ala.</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>Unknown</b>	13b. MOTHER'S MAIDEN NAME <b>Unknown</b>	14. NAME OF HUSBAND OR WIFE <b>Frank L. Chestain</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No.</b>	16. SOCIAL SECURITY NO. <b>No.</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. Louise Jones Spfld. Mo.</b>	ADDRESS
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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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral hemorrhage, subarachnoid.</b>		INTERVAL BETWEEN ONSET AND DEATH  <b>3 weeks</b>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b) _____  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? <b>330x</b> YES <input type="checkbox"/> NO <input type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **5-17, 1951**, to **6/11, 1951**, that I last saw the deceased alive on **6/11, 1951**, and that death occurred at **12:30 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>W. Wood</b>	23b. ADDRESS <b>205 St. Louis St Springfield, Mo.</b>	23c. DATE SIGNED <b>6/11/51</b>
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24a. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>6-13-51</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Greenlawn Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>Springfield, Mo.</b>
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DATE REC'D BY LOCAL REG. <b>6-12-51</b>	REGISTRAR'S SIGNATURE <b>W. Wood</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>J.W. Klingner &amp; Co.</b>	ADDRESS <b>Springfield, Mo.</b>
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(Licensed Embalmer's Statement on Reverse Side)

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

STATE BOARD OF HEALTH  
DIVISION OF HEALTH  
1955

JAN 5 1955

**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 *Max Rhodes*

Licensed Embalmer No. *4071*

P. O. Address *Springfield*

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.