

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

State File No. **45188**

FILED JAN 16 1953

BIRTH NO. _____ REG. DIST. NO. **333** PRIMARY REG. DIST. **#489** Registrar's No. **247**

1. PLACE OF DEATH a. COUNTY Scott		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Scott Mo b. COUNTY Scott	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN VANDUSER Mo.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN VANDUSER	
d. FULL NAME OF HOSPITAL OR INSTITUTION HOME		d. STREET ADDRESS (If rural, give location) -----	

3. NAME OF DECEASED a. (First) WILLIAM b. (Middle) CALVIN c. (Last) CHRONISTER			4. DATE OF DEATH (Month) (Day) (Year) 12-23-52			
5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH 1-20-1879	9. AGE (In years last birthday) 73	IF UNDER 1 YEAR Months Days	IF UNDER 10 HRS. Hours Mins.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RET. FARMER	10b. KIND OF BUSINESS OR INDUSTRY 	11. BIRTHPLACE (City and State or Foreign Country) CLARKSVILLE ARK 1	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME HENRY CHRONISTER	13b. MOTHER'S MAIDEN NAME 	14. NAME OF HUSBAND OR WIFE ELSIE MAY
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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) NO	16. SOCIAL SECURITY NO. 	17. INFORMANT'S SIGNATURE OR NAME ADDRESS A.L. Chronister - Longbeach Miss
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Myocarditis		INTERVAL BETWEEN ONSET AND DEATH
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.	DUE TO (b) _____ DUE TO (c) _____		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> 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 First Case after Death, 1952, that I last saw the deceased alive on , 1952, and that death occurred at m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Clyde Rose Coroner	23b. ADDRESS Sikeston Mo	23c. DATE SIGNED 12/26/52
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 12-25-52	24c. NAME OF CEMETERY OR CREMATORY Garden of Memories Sikeston Mo.	24d. LOCATION (City, town, or county) (State) Mo.
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DATE REC'D BY LOCAL REG. 1-6-53	REGISTRAR'S SIGNATURE Mrs. Ella Hunter	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Welch Funeral Home Sikeston Mo.
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(Licensed Embalmer's Statement on Reverse Side)

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

JAN 12 1953
JAN 5 1953

RECEIVED

SCOTT COUNTY HEALTH CENTER

CO. FILE NO. 153-11

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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.