

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

**17756**

FILED JUN 8 1953

State File No. ....

BIRTH NO. _____		REG. DIST. NO. <u>128</u>		PRIMARY REG. DIST. NO. <u>5466</u>		Registrar's No. <u>515</u>			
1. PLACE OF DEATH a. COUNTY <u>Greene</u> <span style="float:right">0390 2</span>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>New York</u> b. COUNTY <u>8310</u>					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural, S. Campbell Twp.</u>		c. LENGTH OF STAY (in this place) <u>1 yr 9 mo</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>180th, New York City</u> <span style="float:right">8</span>					
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>Medical Center for Federal Prisoners</u>				d. STREET ADDRESS (If rural, give location) <u>Unknown</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>Henry</u>			b. (Middle) <u>-----</u>			c. (Last) <u>Chavarria</u>			
4. DATE OF DEATH (Month) (Day) (Year) <u>May 30, 1953</u>									
5. SEX <u>Male 4</u>	6. COLOR OR RACE <u>Puerto Rican</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widower 2</u>	8. DATE OF BIRTH <u>October 15, 1895</u>	9. AGE (In years last birthday) <u>57</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HOURS Hours	IF UNDER 60 MIN. Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cafe Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cafe</u>		11. BIRTHPLACE (State or foreign country) <u>Puerto Rico</u> <span style="float:right">3</span>		12. CITIZEN OF WHAT COUNTRY? <u>Puerto Rico</u>			
13a. FATHER'S NAME <u>Jose Chavarria Jimenez</u>			13b. MOTHER'S MAIDEN NAME <u>Francis Tehadas</u>			14. NAME OF HUSBAND OR WIFE <u>Mary Flores</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>FILE: M.C.F.P., Springfield, Missouri</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.				<b>MEDICAL CERTIFICATION</b>				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Atelectasis and broncho-pneumonia</u>									
ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u>				DUE TO (b) <u>Paralysis of respiratory muscle</u>					
				DUE TO (c) <u>Amytrophic lateral sclerosis</u>					
II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u>									
19a. DATE OF OPERATION <u>-----</u>		19b. MAJOR FINDINGS OF OPERATION <u>-----</u>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>-----</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>-----</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>3561</u>					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>-----</u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>-----</u>					
22. I hereby certify that <u>the Medical Staff</u> attended the deceased from <u>Aug. 12, 1951, to May 30, 1953</u> , that I last saw the deceased alive on <u>May 30, 1953</u> , and that death occurred at <u>11:30 a.m.</u> , from the causes and on the date stated above.									
23a. SIGNATURE (Name or title) <u>Luzanne Koehler M.D.</u> <u>Cleopatra Kooiker, M.D., Actg. Dir. Director</u>				23b. ADDRESS <u>Medical Center for Fed. Prisoners, Springfield, Mo.</u>		23c. DATE SIGNED <u>6-1-53</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>6/2/1953</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Green Lawn Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Springfield, Missouri</u>			
DATE REC'D BY LOCAL REG. <u>6-2-53</u>		REGISTRAR'S SIGNATURE <u>E. W. Williamson</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>AYRE-GOODWIN FUN'L SERVICE, Spngfld, Mo.,</u>					

(Licensed Embalmer's Statement on Reverse Side)

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

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.....

*Harry C. [Signature]*

Signed.....  
Student Embalmer

Licensed Embalmer No. 4594

P. O. Address..... Springfield, Mi

**Note:** The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.