

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

 BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 140

FILED FEB 15 1954

1. PLACE OF DEATH a. COUNTY Buchanan			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Buchanan		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph		c. LENGTH OF STAY (In this place) 60 years	c. CITY OR TOWN St. Joseph		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Parkview-Sunnyslope Nursing Home 3225 So. 11th St.			e. STREET ADDRESS (If rural, give location) 2813 Francis St.		
3. NAME OF DECEASED (Type or Print) a. (First) William b. (Middle) C. c. (Last) Chesbro			4. DATE OF DEATH (Month) (Day) (Year) February 5, 1954		
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH September 3, 1864	9. AGE (In years last birthday) 89	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ret. locksmith & machinist		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Huntington, Indiana		12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Harriet Warner	14. NAME OF HUSBAND OR WIFE Alice		
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. none	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Anna Barnes 1915 N.4th, St. Joseph, 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) Cardio Vascular Renal Disease ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Senility DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH unknown
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 442x				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 <u>1-29</u> , 19 <u>54</u> , to <u>2-5</u> , 19 <u>54</u> , that I last saw the deceased alive on <u>2-3</u> , 19 <u>54</u> , and that death occurred at <u>4:20 p.m.</u> , from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) <i>H F Mundy M.D.</i>			23b. ADDRESS 2801 Sacramento St. St. Joseph, Mo.		23c. DATE SIGNED 2/9/54
24a. BURIAL, CREMATION, REMOVAL (Specify) burial	24b. DATE 2/8/1954	24c. NAME OF CEMETERY OR CREMATORY Ashland Cemetery	24d. LOCATION (City, town, or county) (State) St. Joseph, Missouri		
DATE REC'D BY LOCAL REG Feb 11, 1954	REGISTRAR'S SIGNATURE <i>Kathleen M. Allison</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Newton Bowman</i>		ADDRESS St. Joseph, Mo.

(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, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Regene Wood*.....

Licensed Embalmer No... *3864*

P. O. Address *319 510th St*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.