

FILED FEB 23 1955

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH 4386 State File No. 5695

BIRTH NO. _____ REG. DIST. NO. 254 PRIMARY REG. DIST. NO. 5867 Registrar's No. 10

1. PLACE OF DEATH a. COUNTY Oregon 0750		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Oregon	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Thayer		c. CITY OR TOWN Thayer	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION		e. STREET ADDRESS (If rural, give location) 0750	

3. NAME OF DECEASED (Type or Print) a. (First) LENA b. (Middle) CHANEY c. (Last) CHANEY			4. DATE OF DEATH (Month) (Day) (Year) Feb. 6, 1955			
5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH May 16, 1876	9. AGE (In years last birthday) 78	IF UNDER 1 YEAR Months Days	IF UNDER 4 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) Hartselle, Alabama		12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Tom Milligan	13b. MOTHER'S MAIDEN NAME Minerva Flowers	14. NAME OF HUSBAND OR WIFE John Chaney
---------------------------------	-------------------------------------------	-----------------------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME Mrs. Grace Black	ADDRESS Thayer, 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		INTERVAL BETWEEN ONSET AND DEATH 7 days
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertensive CV disease 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? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
------------------------	----------------------------------	----------------------------------------------------------------------------------

21a. ACCIDENT (Specify) SUICIDE HOMICIDE	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) m.	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 1954, 18, to 1955, 19, that I last saw the deceased alive on 2-5-55, 19, and that death occurred at 9:00a m., from the causes and on the date stated above.

23a. SIGNATURE [Signature]	(Degree or title) O.M.P.	23b. ADDRESS Mammoth Spring, Ark	23c. DATE SIGNED 2-11-55
----------------------------	--------------------------	----------------------------------	--------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 2-8-55	24c. NAME OF CEMETERY OR CREMATORY Thayer Cemetery	24d. LOCATION (City, town, or county) (State) Thayer, Mo.
--------------------------------------------------	------------------	----------------------------------------------------	-----------------------------------------------------------

DATE REC'D BY LOCAL REG. 2-14-55	REGISTRAR'S SIGNATURE Arthur Wolff	25. FUNERAL DIRECTOR'S SIGNATURE [Signature]	ADDRESS [Address]
----------------------------------	------------------------------------	----------------------------------------------	-------------------

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 *Edward Oates*.....

Licensed Embalmer No..... 4516

P. O. Address *Harlem*.....

**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.**