

TYPE/PRINT IN PERMANENT BLACK INK FOR INSTRUCTIONS SEE OTHER SIDE AND HANDBOOK.

MISSOURI DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

STATE FILE NUMBER

Filed FEB 22 2000

REGISTRATION DISTRICT NO. 114

REGISTRAR'S NUMBER

DELAYED 234996

124-58-047352

DECEDENT

VS 300

SENT FROM NAY DEAN ANDERSON, COPY OF THE OBITUARY REYNOLDS CO. MO. FOR USE BY PHYSICIAN OR INSTITUTION

PARENTS

INFORMANT

DISPOSITION

FILED ON THE BASIS OF A NOTARIZED ANDERSON, COPY OF TOMBSTONE PASSED AWAY NOV. 25 1958

CAUSE OF DEATH

FILED ON THE BASIS OF A NOTARIZED ANDERSON, COPY OF TOMBSTONE PASSED AWAY NOV. 25 1958

CERTIFIER

1. DECEDENT'S NAME (First, Middle, Last) **Eva Lena Chitwood**

2. SEX **Female**

3. DATE OF DEATH (Month, Day, Year) **November 25, 1958**

4. SOCIAL SECURITY NO. **None**

5a. AGE - Last Birthday (Years) **77**

5b. UNDER 1 YEAR MONTHS DAYS

5c. UNDER 1 DAY HOURS MINUTES

6. DATE OF BIRTH (Month, Day, Year) **Dec 25, 1887**

7. BIRTHPLACE (City and State or Foreign Country) **Jefferson County, MO.**

8. WAS DECEDENT EVER IN U.S. ARMED FORCES? Yes No Unk.

9a. PLACE OF DEATH (Check only one, see instructions on other side)

HOSPITAL: Inpatient ER/Outpatient DOA OTHER: Nursing Home Residence Other (Specify)

9b. FACILITY NAME (If not institution, give street and number) **Hwy 21 George Randolph Residence South**

9c. CITY, TOWN, OR LOCATION OF DEATH **Ellington**

9d. COUNTY OF DEATH **Reynolds**

10. MARITAL STATUS - Married, Never Married, Widowed, Divorced, (Specify) **Married**

11. SURVIVING SPOUSE'S NAME (If wife, give full maiden name) **Wayne Chitwood**

12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.) **Housewife**

12b. KIND OF BUSINESS OR INDUSTRY **Residence**

13a. RESIDENCE - STATE **Missouri**

13b. COUNTY **Reynolds**

13c. CITY, TOWN, OR LOCATION **Ellington**

13d. ZIP CODE **63638**

13e. STREET AND NUMBER **Logan Township**

13f. INSIDE CITY LIMITS Yes No

13g. YEARS AT PRESENT ADDRESS Under 5 5-9 10-19 20 or more

14. WAS DECEDENT OF HISPANIC ORIGIN (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.) No Yes Specify:

15. RACE - American Indian, Black, White, etc. (Specify) **White**

16. DECEDENT'S EDUCATION (Specify only highest grade completed)

Elementary/Secondary (0-12) **unknown** College (1-4 or 5+)

17. FATHER'S NAME (First, Middle, Last) **Gus Stroup**

18. MOTHER'S NAME (First, Middle, Maiden Surname) **Clara Todd**

19a. INFORMANT'S NAME (Type/Print) **Nay Dean Masterson**

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) **RT. 1 Box 388 Ellington, MO. 63638**

20a. BURIAL, CREMATION, OTHER (Specify) **Burial**

20b. DATE OF DISPOSITION (Month, Day, Year) **Nov. 29, 1958**

20c. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) **Corridon-Reynolds Cem.**

20d. LOCATION - City or Town, State **Reynolds, MO.**

21. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH

22a. NAME AND ADDRESS OF FACILITY **McSpadden Funeral Home, Inc. 610 South Main Ellington, MO. 63638**

22b. FUNERAL ESTABLISHMENT LICENSE NUMBER **2400**

23. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) **Kidney Failure**

DUE TO (OR AS A CONSEQUENCE OF):

Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24. IF DECEASED WAS FEMALE 10-49, WAS SHE PREGNANT IN THE LAST 90 DAYS? Yes No Unk.

25a. WAS AN AUTOPSY PERFORMED? Yes No

25b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? Yes No

26. MANNER OF DEATH Natural Pending Investigation Accident Suicide Could not be Determined Homicide

27a. DATE OF INJURY (Month, Day, Year)

27b. TIME OF INJURY

27c. WAS INJURY ALCOHOL-RELATED? (Not limited to decedent.) Yes No Unk.

27d. INJURY AT WORK? Yes No Unk.

27e. DESCRIBE HOW INJURY OCCURRED

27f. PLACE OF INJURY - At home, farm street, factory, office building, etc. (specify)

27g. LOCATION (Street and Number or Rural Route Number, City or Town, State)

28a. (Specify) CERTIFYING PHYSICIAN MEDICAL EXAMINER/CORONER

28b. To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) stated. (Signature and Title)

28c. DATE SIGNED (Month, Day, Year) **Feb. 14, 2000**

28d. TIME OF DEATH **3:50 P. M**

29a. NAME AND ADDRESS OF CERTIFIER (PHYSICIAN, MEDICAL EXAMINER OR CORONER) (Type or Print) **Jeff McSpadden 610 So. Main Ellington, MO. 63638**

29b. MO. LICENSE NUMBER

30. WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? Yes No

31. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)

32. REGISTRAR'S SIGNATURE

33. DATE RECEIVED BY LOCAL REGISTRAR (Month, Day, Year) **Feb. 22 - 2000**

7-cy	12a	23u	27g-co
9a	13e	23-sc1	29g-cy
9b	13b	27-sc2	29a
9c	14	27e-f	29b
12b	15	27g-st	

DO NOT WRITE ON THIS STUB

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 Body was Embalmed By Bud Parrott
Licensed Embalmer No. _____

NAME OF DECEDENT EVA Lena CHITWOOD

P.O. Address Ellington, Mo.

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.

INSTRUCTIONS FOR SELECTED ITEMS

Item 9a - Place of Death

If the death was pronounced in a hospital, check the box indicating the decedent's status at the institution (inpatient, emergency room/outpatient, or dead on arrival (DOA)). If death was pronounced elsewhere, check the box indicating whether pronouncement occurred at a nursing home, residence, or other location. If other is checked, specify where death was legally pronounced, such as a physician's office, the place where the accident occurred, or at work.

Item 13a-g - Residence of Decedent

Residence of the decedent is the place where he or she actually resided. This is not necessarily the same as "home state," or "legal residence." Never enter a temporary residence such as one used during a visit, business trip, or a vacation. Place of residence during a tour of military duty or during attendance at college is not considered as temporary and should be considered as the place of residence. If a decedent had been living in a facility where an individual usually resides for a long period of time, such as a group home, mental institution, nursing home, penitentiary, or hospital for the chronically ill, report the location of that facility in items 13a through 13g. If the decedent was an infant who never resided at home, the place of residence is that of the parent(s) or legal guardian. Do not use an acute care hospital's location as the place of residence for any infant.

Item 23 - Cause of Death

The cause of death means the disease, abnormality, injury or poisoning that caused the death, not the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. In Part I the immediate cause of death is reported on line (a). Antecedent conditions, if any, which gave rise to the cause are reported on lines (b), (c), and (d). The underlying cause should be reported on the last line used in Part I. No entry is necessary on lines (b), (c), and (d) if the immediate cause of death on line (a) describes completely the chain of events. ONLY ONE CAUSE SHOULD BE ENTERED ON A LINE. Additional lines may be added if necessary. Provide the best estimate of the interval between the onset of each condition and death. Do not leave the interval blank; if unknown, so specify. In Part II, enter other important diseases or conditions that may have contributed to death but did not result in the underlying cause of death given in Part I.

EXAMPLE OF PHYSICIAN CERTIFICATION:

CAUSE OF DEATH

23. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE → <i>(Final disease or condition resulting in death)</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (disease or injury that initiated events resulting in death) LAST	a.	Rupture of myocardium			Mins	
	DUE TO (OR AS A CONSEQUENCE OF):					
	b.	Acute myocardial infarction			6 days	
	DUE TO (OR AS A CONSEQUENCE OF):					
c.	Chronic ischemic heart disease			5 years		
DUE TO (OR AS A CONSEQUENCE OF):						
d.						
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						
Diabetes, Chronic obstructive pulmonary disease, smoking						
24. IF DECEASED WAS FEMALE 10-49, WAS SHE PREGNANT IN THE LAST 90 DAYS?		25a. WAS AN AUTOPSY PERFORMED?		25 b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
26. MANNER OF DEATH		27a. DATE OF INJURY (Month, Day, Year)	27b. TIME OF INJURY	27c. WAS INJURY ALCOHOL-RELATED? (Not limited to decedent)	27d. INJURY AT WORK?	27e. DESCRIBE HOW INJURY OCCURRED
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Homicide			M.	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNK.	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNK.	
27f. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify)				27g. LOCATION (Street and Number or Rural Route Number, City or Town, State)		

EXAMPLE OF MEDICAL EXAMINER OR CORONER

CAUSE OF DEATH

23. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE → <i>(Final disease or condition resulting in death)</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (disease or injury that initiated events resulting in death) LAST	a.	Cerebral laceration			10 mins.	
	DUE TO (OR AS A CONSEQUENCE OF):					
	b.	Open skull fracture			10 mins.	
	DUE TO (OR AS A CONSEQUENCE OF):					
c.	Automobile accident			10 mins.		
DUE TO (OR AS A CONSEQUENCE OF):						
d.						
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						
24. IF DECEASED WAS FEMALE 10-49, WAS SHE PREGNANT IN THE LAST 90 DAYS?		25a. WAS AN AUTOPSY PERFORMED?		25 b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unk.		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
26. MANNER OF DEATH		27a. DATE OF INJURY (Month, Day, Year)	27b. TIME OF INJURY	27c. WAS INJURY ALCOHOL-RELATED? (Not limited to decedent)	27d. INJURY AT WORK?	27e. DESCRIBE HOW INJURY OCCURRED
<input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Homicide		11/15/85	1 p.M.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unk.	2-car collision-driver
27f. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify)				27g. LOCATION (Street and Number or Rural Route Number, City or Town, State)		
Street				Route 4, Jefferson City, Missouri		