Health, Welfare Public Service

300
1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-014797
STATE FILE NUMBER

FILED MAY 1 1959 Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 2884

1. PLACE OF DEATH
a. COUNTY

b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) St. Louis, Inside Limits Yes ☐ No ☐

c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) St. Louis, Little Rock Hospitals, Inc. Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE California b. COUNTY

c. CITY OR TOWN Carlsbad Inside Limits Yes ☐ No ☐

d. STREET ADDRESS (If outside, give location) 1697 Laurel Road Reside on Farm Yes ☒ No ☐

3. NAME OF DECEASED (Type or print) First Ivan Middle G. Last Chaffee

4. DATE OF DEATH Month March Day 22, Year 1959

5. SEX Male

6. COLOR OR RACE White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH January 8, 1893

9. AGE (In years last birthday) 66 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Conductor

10b. KIND OF BUSINESS OR INDUSTRY Railroad

11. BIRTHPLACE (City and state or country) KANSAS

12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME Ora Chaffee

13b. MOTHER'S MAIDEN NAME Unk

14. NAME OF HUSBAND OR WIFE Garnett Chaffee

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Don't Know

16. SOCIAL SECURITY NO. 702-14-3333

17. INFORMANT Address John Chaffee 3624 Shaw Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of the Prostate with metastasis to lymph nodes, vertebrae and liver. INTERVAL BETWEEN ONSET AND DEATH 3 mo
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Duodenal ulcer 177X

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from February 23, 1959, to March 22, 1959 and last saw him alive on March 21, 1959
Death occurred at 6:05 AM m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Leland E. Hasto M.D.

22b. ADDRESS 1755 South Grand Ave.

22c. DATE SIGNED 3-22-59

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal

23b. DATE 3/22/59

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City, town, or county) (State) Fall City Nebraska

24. FUNERAL DIRECTOR Dorr and Roberts ADDRESS Falls City, Nebr.

25. DATE RECD. BY LOCAL REG. MAR 22 '59

26. REGISTRAR'S SIGNATURE Earl Smith. M.D. M.J.B.

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

VS MAY 1 1959

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 Clarence Billo

Licensed Embalmer No. 4375

P. O. Address St. Louis

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.