

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-018628

FILED JUN 8 1959 Registration District No. 274 Primary Registration District No. 3052 STATE FILE NUMBER Registrar's No. 175

1. PLACE OF DEATH a. COUNTY <i>Pettis</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo</i> b. COUNTY <i>Pettis</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Sedalia</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>Sedalia</i> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>917 W. 10th St.</i>		Length of stay in lb <i>88 yrs.</i>	d. STREET ADDRESS (If outside, give location) <i>917 W 10th St.</i> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <i>NANCY</i> Middle <i>ELIZABETH</i> Last <i>CHANEY</i>			4. DATE OF DEATH Month <i>MAY</i> Day <i>24</i> Year <i>1959</i>		
------------------------------------------------------------------------------------------------------	--	--	---------------------------------------------------------------------	--	--

5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec. 2, 1869</i>	9. AGE (In years last birthday) <i>89</i>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.
-------------------------	----------------------------------	-------------------------------------------------------------------------------------------------------------------------------------------------------------	-----------------------------------------	----------------------------------------------	--	-------------------------------------------	-------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <i>Prairie Home Mo.</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
-----------------------------------------------------------------------------------------------------------------	-----------------------------------	-----------------------------------------------------------------------	--------------------------------------------

13a. FATHER'S NAME <i>Harris</i>	13b. MOTHER'S MAIDEN NAME <i>Unknown</i>	14. NAME OF HUSBAND OR WIFE <i>Edward Chaney</i>
-------------------------------------	---------------------------------------------	-----------------------------------------------------

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT <i>Dorothy Stephens</i> Address <i>917 W. 10th St. Sedalia Mo.</i>
-----------------------------------------------------------------------------------------------------------	-------------------------	----------------------------------------------------------------------------------------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary edema</i>		INTERVAL BETWEEN ONSET AND DEATH <i>49 hours</i>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <i>Myocardial degeneration</i>		<i>1 week</i>
	DUE TO (c) <i>Old age</i>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>4222</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
-----------------------------------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------

20c. TIME OF INJURY Hour Month, Day, Year o.m. p.m.	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	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 <i>1949</i> to <i>May 24, 1959</i> and last saw her <sup>her</sup> <sub>him</sub> alive on <i>May 24, 1959</i> Death occurred at <i>9:10</i> a. m on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE (Degree or title) <i>H. W. Wilbur, D.O.</i>	22b. ADDRESS <i>Sedalia, Mo.</i>	22c. DATE SIGNED <i>5/26/59</i>

23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>May 26, 1959</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Lained Oak</i>	23d. LOCATION (City, town, or county) (State) <i>Windsor Mo.</i>
------------------------------------------------------------	----------------------------------	---------------------------------------------------------	---------------------------------------------------------------------

24. FUNERAL DIRECTOR <i>B. M. Houston</i>	ADDRESS <i>Windsor Mo.</i>	25. DATE RECD. BY LOCAL REG. <i>6/4/1959</i>	26. REGISTRAR'S SIGNATURE <i>Frances Shelby</i>
----------------------------------------------	-------------------------------	-------------------------------------------------	----------------------------------------------------

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *E. M. Houston* .....

Licensed Embalmer No. *3391* .....

P. O. Address *Windsor 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.