

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-020945  
STATE FILE NUMBER

FILED JUL 14 1959

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 725-B

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

William W. Wood, M.D.  
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If in institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Laclede</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Bennett Springs</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Springfield</u>		Length of stay in 1b	d. STREET ADDRESS <u>R.R.</u> (If outside, give location)
3. NAME OF DECEASED (Type or print) First <u>BENJAMIN</u> Middle <u>H.C.</u> Last <u>HASTAIN</u>		4. DATE OF DEATH Month <u>6</u> Day <u>29</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-20-1888</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>farm</u>	9. AGE (In years last birthday) <u>71</u>
11. BIRTHPLACE (City and state or country) <u>Dallas Co Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Jacob Chastain</u>		13b. MOTHER'S MAIDEN NAME <u>Belle Chastain</u>	
14. NAME OF HUSBAND OR WIFE <u>Belle Chastain</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT <u>Belle Chastain</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Nephrosclerosis with uremia.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic heart disease</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>446X</u>			
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 a.m. p.m.		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20e. CITY, TOWN, OR LOCATION		20f. COUNTY STATE	
21. I attended the deceased from <u>Sept 1958</u> to <u>6/29/59</u> and last saw him alive on <u>6/29/59</u> Death occurred at <u>11:30 am</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>William Wood M.D.</u>		22b. ADDRESS <u>Springfield, Mo</u>	
22c. DATE SIGNED <u>7/3/59</u>		23a. BURIAL, CREMATION, REMOVAL (Specify)	
23b. DATE <u>7-2-1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Flaterwoods</u>	
23d. LOCATION (City, town, or county) <u>Dallas Co Mo</u>		24. FUNERAL DIRECTOR <u>L.B. Jones</u>	
24. ADDRESS <u>Raymo, Mo</u>		25. DATE RECD. BY LOCAL REG. <u>7-7-59</u>	
26. REGISTRAR'S SIGNATURE <u>Effie B. Melton</u>		(Licensed Embalmer's Statement on Reverse Side)	

JUL 24 1955

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 *Leonard B. Jones* .....

Licensed Embalmer No. *2508* .....

P. O. Address *Buffalo, N.Y.* .....

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.