

INDEXED

Registration District No. 274 Primary Registration District No. 2052 Registrar's No. 234 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Pettis</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Sedalia</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Bothwell Hospital</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Henry</u> c. CITY OR TOWN <u>Glinton RR# 2</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>Springfield twap</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Length of stay in 1b <u>10 min</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Jerry</u> Middle <u>Earl</u> Last <u>Chastain</u>			4. DATE OF DEATH Month <u>July</u> Day <u>12</u> Year <u>1959</u>			
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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>8/18/90</u>	9. AGE (last birthday) <u>68</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (City and state or country) <u>Henry Co. Missouri</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>Jim Chastain</u>	13b. MOTHER'S MAIDEN NAME <u>Tabetha Briggs</u>	14. NAME OF HUSBAND OR WIFE <u>Florence Maude Chastain</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes WW#1</u>	16. SOCIAL SECURITY NO. <u>496-32-6542</u>	17. INFORMANT Address <u>Kenneth Chastain, Sedalia, Missouri</u>
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18. CAUSE OF DEATH (Enter only one cause by line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>8 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	20d. INJURY OCCURRED WHILE AT WORK <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
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21. I attended the deceased from 7/12/59 to 7/12/59 and last saw him alive on 7/12/59
 Death occurred at 12:15 P on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Thomas J. Hyatt, M.D.</u>	22b. ADDRESS <u>Sedalia, Mo</u>	22c. DATE SIGNED <u>7/12/59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>7/14/1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calhoun city cem.</u>	23d. LOCATION (City, town, or county) (State) <u>Calhoun, Missouri</u>
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24. FUNERAL DIRECTOR ADDRESS <u>Consalus Clinton, Missouri</u>	25. DATE RECD. BY LOCAL REG. <u>7-14-1959</u>	26. REGISTRAR'S SIGNATURE <u>Frances Shelby</u>
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DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

AUG 6 1958

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 KPTM Crum

Licensed Embalmer No. 3153

P. O. Address Sedalia

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.