

REGISTRATION DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-031500

FILED VS OCT 13 1959 042

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 992

STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Buchanan</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Joseph</b>		Length of stay in 1b <b>28 years</b>		c. CITY OR TOWN <b>St. Joseph</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Mo. Meth. Hosp.</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>1120 Main St.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>HARRY</b> Middle <b>F.</b> Last <b>CHESMORE</b>				4. DATE OF DEATH Month <b>Sept.</b> Day <b>26,</b> Year <b>1959</b>				
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>10/31/1877</b>	9. AGE (last birthday) <b>81</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	IF UNDER 24 HR Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Physician</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Maysville, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Alfred M. Chesmore</b>			13b. MOTHER'S MAIDEN NAME <b>Lucy E. Brown</b>			14. NAME OF HUSBAND OR WIFE -----		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>497-12-1578</b>		17. INFORMANT Address <b>St. Joseph, Mo.</b> <b>Mrs. Bertha Chesmore, 1214 N. 26th,</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Epithelioma of lip - right</b> Secondary to draining sinus DUE TO (b) <b>Osteomyelitis of incisors</b> DUE TO (c) <b>Osteomyelitis of incisors</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b> <b>2 1/2 yrs</b> <b>77 yrs</b>		
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.)				
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____		Month, Day, Year _____						
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		
21. I attended the deceased from <b>Jan. 3, 1957</b> to <b>Sept 26, 1959</b> and last saw him alive on <b>Sept 26, 1959</b> Death occurred at <b>12:35p.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree printed) <b>S.F. Seneor M.D.</b>				22b. ADDRESS <b>St. Joseph Mo</b>		22c. DATE SIGNED <b>9-28-59</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE <b>9/29/1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Mora Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Joseph Missouri</b>			
24. FUNERAL DIRECTOR ADDRESS <b>Haton-Bourman St. Joseph, Mo.</b>			25. DATE RECD. BY LOCAL REG. <b>Oct. 1, 1959</b>		26. REGISTRAR'S SIGNATURE <b>Mr. Clark Landell</b>			

DOCUMENT

BY AFFIDAVIT OF S.F. Seneor, M.D. MEDICAL CERTIFICATION

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Eugene Wood

Licensed Embalmer No. 3804

P. O. Address 319 So 10th St

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to co  
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.