

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS DEC 15 1959

59-043130

STATE FILE NUMBER

Registration District No. 360 Primary Registration District No. 6225 Registrar's No. 203

ENDED

1. PLACE OF DEATH a. COUNTY <u>Vernon</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Henry</u>					
b. CITY (if outside corporate limits, give TOWNSHIP only) <u>Washington Township</u>		Length of stay in 1b <u>71 Mo. 5 Da.</u>		c. CITY OR TOWN <u>Clinton</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>State Hosp. # 3 Nevada, Mo.</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>717 East Green</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Donnie</u> Middle <u>-----</u> Last <u>Chanlor</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>5</u> Year <u>1959</u>					
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>5-18-1887</u>	9. AGE (last birthday) <u>72</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HR Hours <u> </u> Min. <u> </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (City and state or country) <u>Kentucky</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13a. FATHER'S NAME <u>William S. Gardner</u>			13b. MOTHER'S MAIDEN NAME <u>Mathilda Ann Hicks</u>			14. NAME OF HUSBAND OR WIFE <u>Frank P. Chanlor</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Hospital Records State Hosp. #3 Nevada, Mo</u> Address <u> </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>Bronchopneumonia</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>Hip Fracture - left.</u>							2 months		
DUE TO (c) <u> </u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Generalized Arteriosclerosis</u>						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 checked="" 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.) <u>Fallen Ward</u>							
20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. <u> </u> Month, Day, Year <u>10-9-59</u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> <u>Fracture left Hip.</u>								
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Ward - State Hosp. Nevada - Vernon Mo</u>		20f. CITY, TOWN, OR LOCATION <u>Clinton, Mo.</u>		20g. COUNTY <u>Henry</u>		20h. STATE <u>Mo</u>			
21. I attended the deceased from <u>Dec 30, 1958</u> to <u>Dec 5, 1959</u> and last saw her/him alive on <u>Dec 5, 1959</u> Death occurred at <u>9:05 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <u>Paul L Barone MD</u>				22b. ADDRESS <u>State Hospital Nevada Mo Dec 7/59</u>				22c. DATE SIGNED <u>Dec 7/59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>12/6/59</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Englewood Cemetery</u>			23d. LOCATION (City, town, or county) (State) <u>Clinton, Mo.</u>		
24. FUNERAL DIRECTOR <u>Consalus Funeral Home, Clinton, Mo.</u>				25. DATE REC'D. BY LOCAL REG. <u>Dec 10 - 1959</u>		26. REGISTRAR'S SIGNATURE <u>Anna E Perry</u>			

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MS DEC 17 1959

DEC 18 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
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed R Percy F. Milster

Licensed Embalmer No. 4805

P. O. Address Newark, N.J.

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