

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-034527

FILED VS OCT 10 1960

STATE FILE NUMBER

Registration District No. 133 Primary Registration District No. 3022 Registrar's No. 115

1. PLACE OF DEATH a. COUNTY <u>Harrison</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Gentry</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Bethany</u>		Length of stay in 1b <u>9 days</u>		c. CITY OR TOWN <u>Albany</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>Lacy Convalescent Home</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>301 E. Clay</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>WILLIAM</u> Last <u>CHENOWETH</u>				4. DATE OF DEATH Month <u>October</u> Day <u>5</u> Year <u>1960</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>2/2/69</u>		9. AGE (last birthday) <u>91</u> IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Veterinarian</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Vet. Medicine</u>		11. BIRTHPLACE (City and state or country) <u>Green Castle, Indiana</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>		
13a. FATHER'S NAME <u>Robert Beatty</u>			13b. MOTHER'S MAIDEN NAME <u>Elizabeth Dun</u>			14. NAME OF HUSBAND OR WIFE <u>Ruby Wheatley Chenoweth</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.		17. INFORMANT Address <u>Mrs John W. Chenoweth Albany, Mo.</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>Hemorrhage from urinary tract</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Benign Prostatic Hypertrophy</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Arteriosclerotic Heart Disease & Mitral Regurgitation.</u>							INTERVAL BETWEEN ONSET AND DEATH <u>8 hours</u> <u>years.</u>		
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 _____ 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		
21. I attended the deceased from <u>10-3-60</u> to <u>10-5-60</u> and last saw him alive on <u>10-5-60</u> Death occurred at <u>8:00 A</u> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>Albert Trinkle M.D.</u> (Degree or title)					22b. ADDRESS <u>Box 33, Bethany, Mo.</u>		22c. DATE SIGNED <u>10-6-60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE <u>Oct. 7, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>King City</u>		23d. LOCATION (City, town, or county) (State) <u>King City Missouri</u>			
24. FUNERAL DIRECTOR <u>Brooks-Cochell Funeral Home Albany, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>October 6-1960</u>		26. REGISTRAR'S SIGNATURE <u>Jella Mapey</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

OCT 18 1960

DEC 27 1960

MAY 9 1961

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 me _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Donald E. Cook

Licensed Embalmer No. 4868

P. O. Address Albany, Mo.

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