

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-029168

3697

STATE FILE NUMBER

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

AUG 16 1961

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY JACKSON	b. CITY (if outside corporate limits, give TOWNSHIP only) KANSAS CITY	a. STATE ARKANSAS	b. COUNTY FULTON
Length of stay in 1b 6 MONTHS		c. CITY OR TOWN VIOLA	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION 8034 WALDRON	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS N.E. 3 MILES	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH	
First CHARLES	Middle LAFAYETTE	Last CHESNUT	Month JULY	Day 24
Year 1961				
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1-12-1902	9. AGE (last birthday) 59
IF UNDER 1 YEAR Months Days		IF UNDER 24 HR Hours Min.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER	10b. KIND OF BUSINESS OR INDUSTRY FARM	11. BIRTHPLACE (City and state or country) SALEM, ARKANSAS	12. CITIZEN OF WHAT COUNTRY U. S. A.
---	---	---	---

13a. FATHER'S NAME MATT CHESNUT	13b. MOTHER'S MAIDEN NAME ELLEN BURGESS	14. NAME OF HUSBAND OR WIFE ETHEL CHESNUT
------------------------------------	--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	16. SOCIAL SECURITY NO.	17. INFORMANT K.C. Mo. ETHEL CHESNUT 8034 WALDRON
--	-------------------------	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Pulmonary Fibrosis + metastatic Carcinoma of Lung		6 months
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	6 years
	DUE TO (c)	

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 May 1961 to July 1961 and last saw her/him alive on July 23, 1961  
Death occurred at 2:00 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE William L. Doane MD	(Degree or title)	22b. ADDRESS 1102-130th St. Grandview, MO. 7-2461	22c. DATE SIGNED
---------------------------------------	-------------------	--	------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE JULY 29, 1961	23c. NAME OF CEMETERY OR CREMATORY -	23d. LOCATION (City, town, or county) SALEM, ARKANSAS	(State)
--	----------------------------	---	--	---------

24. FUNERAL DIRECTOR CARTER FUNERAL HOME	ADDRESS SALEM, ARK	25. DATE RECD. BY LOCAL REG. 7-25-61	26. REGISTRAR'S SIGNATURE Ruth Long
---	-----------------------	---	--

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF  
William L. Doane

**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 John R. Fidd

Licensed Embalmer No. 4531

P. O. Address Kansas City

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.