

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-032302

STATE FILE NUMBER

AMENDED

Registration District No. 82 Primary Registration District No. 5320 Registrar's No. 139

FILED OCT 9 1961

1. PLACE OF DEATH a. COUNTY <u>COOPER</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>SABINE</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>PALESTINE TWP.</u>		Length of stay in 1b <u>1 mo</u>	c. CITY OR TOWN <u>MARSHALL</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		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>303 E MITCHELL</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>JAMES WILBUR CHEVALIER</u>			4. DATE OF DEATH Month Day Year <u>Oct. 4, 1961</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</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>1-21-1933</u>
9. AGE (last birthday) <u>28</u>		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) <u>LABOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CRaft Food</u>	11. BIRTHPLACE (City and state or country) <u>MARSHALL, Mo</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>HENRY CHEVALIER</u>	
13b. MOTHER'S MAIDEN NAME <u>MARY Dillon</u>		14. NAME OF HUSBAND OR WIFE <u>NANCY CHEVALIER</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>UNKNOWN</u>	
17. INFORMANT <u>CHARLES J. CHEVALIER</u>		Address <u>MARSHALL</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>Violence</u> DUE TO (b) <u>Burned to death</u> DUE TO (c) <u>Truck wreck</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>5 min</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 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>Burned to death in unburned panel truck</u>			
20c. TIME OF INJURY Hour a.m. Month, Day, Year <u>about 2:40 p.m. 10/4/61</u>		20d. INJURY OCCURRED WHILE AT WORK <input checked="" 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.) <u>Highway 5-8 mo Sabine Co Mo</u>		20f. CITY, TOWN OR LOCATION COUNTY STATE <u>Cooper Mo</u>	
21. I attended the deceased from <u>to arrival</u> and last saw her/him alive on _____ Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Dr. Deane Mo Carner</u>		22b. ADDRESS <u>Brunell Mo</u>	
22c. DATE SIGNED <u>10/5/61</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	
23b. DATE <u>10-6-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>SUNSET Memorial Cemetery</u>	
23d. LOCATION (City, town, or county) <u>MARSHALL Mo</u>		24. FURNERAL DIRECTOR <u>JACK W. RESER</u>	
25. DATE RECD. BY LOCAL REG. <u>10/5/61</u>		26. REGISTRAR'S SIGNATURE <u>Hooper</u>	

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
DATE AMENDED  
INSTEAD OF  
SHOULD READ  
ITEM NO.

DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF

APR 10 1962

DEC 12 1962

JUL 3 1963

**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 Benny W. Shaker

Licensed Embalmer No. 3944

P. O. Address Brownville

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.