

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=62-005226

STATE FILE NUMBER

Registration District No. 360 Primary Registration District No. 6225 Registrar's No. 2

AMENDED

FILED JAN 16 1962

1. PLACE OF DEATH a. COUNTY <u>Vernon</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Webster</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Washington Township</u>		c. CITY OR TOWN <u>Niangua</u>	
Length of stay in lb <u>6mos.</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>State Hospital #3</u>		d. STREET ADDRESS (If outside, give location) <u>Route #2</u>	
Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Ida</u> Middle <u>Chandler</u> Last <u>Chandler</u>			4. DATE OF DEATH Month <u>1</u> Day <u>1</u> Year <u>1962</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>12/30/1884</u>	9. AGE (last birthday) <u>78yrs.</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>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (City and state or country) <u>Missouri</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>Robert McNatt</u>		13b. MOTHER'S MAIDEN NAME <u>Josie Wheeler</u>	
14. NAME OF HUSBAND OR WIFE <u>Unknown</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>None</u>	
17. INFORMANT <u>Hospital Records, Nevada, Mo.</u>		Address			

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) <u>Arteriosclerotic Heart Disease</u>			<u>yrs.</u>
DUE TO (b) <u>General Arteriosclerosis</u>			<u>yrs.</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)			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 <u>12:05</u> 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.) <u>None</u>	20f. CITY, TOWN, OR LOCATION <u>Staff</u>	COUNTY	STATE
21. attended the deceased from <u>6/23/61</u> to <u>1/1/62</u> and last saw her/him alive on <u>12/31/61</u> Death occurred at <u>12:05</u> a.m. on the date stated above, and to the best of my knowledge, from the causes stated. <u>I viewed remains:</u>				

22a. SIGNATURE <u>George Esler, M.D.</u> (Degree or title)	22b. ADDRESS <u>State Hospital #3-Nevada, Mo</u>	22c. DATE SIGNED <u>1/1/62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>1-3-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Blade Oak Cemetery</u>
23d. LOCATION (City, town, or county) <u>Marshfield, Missouri</u>	24. FUNERAL DIRECTOR <u>Barber-Edwards Funeral Home, Marshfield, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>1-8-1962</u>
26. REGISTRAR'S SIGNATURE <u>Arma E. Ferry</u>		

(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 DATE AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF

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 Ray S. Ireland

Licensed Embalmer No. 50525

P.O. Address Nevada, Mo -

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.