16574

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

LACE OF DEATH

County Knox — Registration District No. 441 — File No.

Township Liberty — Primary Registration District No. 6243 — Registered No. 46

City Edina Mo. (No. ..... St. ..... Ward)

ULL NAME Cephas Bascome Chaney

(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

h of residence in city or town where death occurred 25 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

X	4. COLOR OR RACE	5. ~~SINGLE~~, MARRIED, ~~WIDOWED OR DIVORCED (write the word)~~
M.	W.	M

MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF (OR) WIFE OF Edwilda Davis

TE OF BIRTH (MONTH, DAY AND YEAR) March 16-62

E	YEARS	MONTHS	DAYS	If LESS than 1 day, D hrs. or ..... min.
	67	1	29	

CUPATION OF DECEASED

(a) Trade, profession, or articular kind of work Farmer

(b) General nature of industry, usiness, or establishment in which employed (or employer)

(c) Name of employer

RTHPLACE (CITY OR TOWN) Sand hill
(STATE OR COUNTRY) Scotland

. NAME OF FATHER Daniel C. Chaney

. BIRTHPLACE OF FATHER (CITY OR TOWN) Baltimore
(STATE OR COUNTRY) Md.

. MAIDEN NAME OF MOTHER Mary E. Price

. BIRTHPLACE OF MOTHER (CITY OR TOWN) Hurdland
(STATE OR COUNTRY) Mo.

NFORMANT Aubery Chaney
(Address) Kirksville

FILED 6/1 1930 J. O. S. Brown
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5-15 1930

17.

I HEREBY CERTIFY, That I attended deceased from 5-15, 1930, to 5-15, 1930 that I last saw h[illegible] alive on 5-15, 1930, and that death occurred, on the date stated above, at 8:05 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Gangrenous perforation of bowels.

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (SECONDARY) Obstruction - cause unascertained (duration) yrs. mos. 2 ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH?

0 DID AN OPERATION PRECEDE DEATH? no. DATE OF

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) Frederick L. Schmitt D.O. M.D.

5-17, 1930 (Address) Edina, Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Knox City	5-18 1930
20. UNDERTAKER	ADDRESS
J. W. Hudson	Edina

V. S. No. 2.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (No....., ...St. .....W

2. FULL NAME .....

(a) Residence. No..... St., ...Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or .....min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
(STATE OR COUNTRY)

14.
INFORMANT .....
(Address)

15.
FILED....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

17.
I HEREBY CERTIFY, That I attended deceased from .....
.....,19....., to .....,
that I last saw h..... alive on.....,19.....,
death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

.....

.....(duration).....yrs. .....mos.

CONTRIBUTORY.....
(SECONDARY)

.....(duration).....yrs. .....mos.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed).....

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL. (See reverse side for additional space.)

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