

REC'D MAR 9 1939

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

6594

Do not use this space.

1. PLACE OF DEATH

(a) County Greene Registration District No. 322
 (b) Township Franklin Primary Registration District No. 5446 Registered No. 4
 (c) City _____ (d) Street No. _____ St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. 500 STILL BORN Betty Lois Chaney
Fair Grove R 2 St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 3-3-1939

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
6

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Fair Grove R 2

FATHER 13. NAME Boyd M Chaney

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Iowa

MOTHER 15. MAIDEN NAME Bernice M Smelser

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Iowa

17. INFORMANT (ADDRESS) Boyd M Chaney
Fair Grove R 2

18. BURIAL, CREMATION, OR REMOVAL

PLACE Union Grove DATE Mar 3 1939

19. FUNERAL DIRECTOR (ADDRESS) none

20. FILED Mar 3 1939 Allan Barnes
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar 3 1939

22. I HEREBY CERTIFY, That I attended deceased from _____ 19____ to _____ 19____

I last saw her dead Mar 3 1939 Death is said to have occurred on the date stated above, at 9 a. m.

The principal cause of death and related causes of importance were as follows:

Still Born
8 month

Date of onset

Other contributory causes of importance:

Poor Circulation

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased?

If so, specify _____

(Signed) W. E. Albright, M. D.

(Address) Pleasant Hope Mo

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.

STATEMENT BY LICENSED EMBALMER

I, _____, Licensed Embalmer, No. _____

hereby certify that the body recorded on the reverse side of this certificate was embalmed by _____

_____ L. E. _____

No. _____ or by _____, Registered Apprentice No. _____

working under my personal supervision.

Signed _____

Licensed Embalmer No. _____

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.)