

REC'D AUG 4 1939

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

26061  
Do not use this space.

1. PLACE OF DEATH  
 (a) County Lozysayette Registration District No. 460  
 (b) Township \_\_\_\_\_ Primary Registration District No. 4279  
 (c) City or Higginsville (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. da. (f) How long in U.S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME Samuel Chmore Jr.  
 (a) Residence, No. Higginsville, Mo., 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 male 4. COLOR OR RACE Colored 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) widow

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 28, 1872

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, ..... hrs. or ..... min.
	<u>67</u>	<u>4</u>	<u>4</u>	

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. Miner  
 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) Jackson

FATHER  
 13. NAME Samuel Chmore  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky

MOTHER  
 15. MAIDEN NAME Margaret Bradley  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) not known

17. INFORMANT (ADDRESS) Martin Chmore Jr.

18. BURIAL, CREMATION, OR REMOVAL PLACE Higginsville DATE Mar 27, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Mrs. M. L. Deak  
Springfield, Missouri

20. FILED Aug 2 19 39 Tiffany Webb  
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 25, 1939

22. I HEREBY CERTIFY That I attended deceased from Feb 21, 1939, to March 25, 1939  
 I last saw him alive on March 24, 1939. Death is said to have occurred on the date stated above, at 6:50 a.m.  
 The principal cause of death and related causes of importance were as follows:  
Prostatic Hypertrophy  
Chronic Pyelonephritis  
Chronic Cystitis

Date of onset 3/10/39

Other contributory causes of importance: 181

Name of operation none Date of \_\_\_\_\_  
 What test confirmed diagnosis? P.S. Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? no 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? no  
 If so, specify \_\_\_\_\_  
 (Signed) J. S. Steh!, M. D.  
 (Address) Hampden, 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.

REC'D

RECEIVED  
District Health Officer No. 8,  
District File Number  
Date Filed 12/3/39

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed *L. J. Harris, Sr.*

Licensed Embalmer No. *3388*

P. O. Address *Lexington*

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 this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

26061

Do not use this space.

1. PLACE OF DEATH

(a) County Lafayette Registration District No. 460  
(b) Township ..... Primary Registration District No. 4274  
(c) City Heggenville (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

Samuel Elmore Jr.  
(a) Residence, No. .... St.  (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar 25 1939

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

22. I HEREBY CERTIFY, That I attended deceased from 19... to 19... I last saw him alive on 19... Death is said to have occurred on the date stated above, at... m.

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 28 1872

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 68 7 27

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

Date of onset

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

Other contributory causes of importance:

FATHER 13. NAME

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

MOTHER 15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED Sept 11 1939 Tiffany Webb Local Registrar

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) H. C. West, M. D.

(Address) Lepington Mo

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

SUPPLEMENTARY

1939  
S-26061.