

2399 OCT 12 1939

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

32521  
Do not use this space.

1. PLACE OF DEATH  
 (a) County Howard Registration District No. 380  
 (b) Township 1 Primary Registration District No. 4224  
 (c) City New Franklin (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 Josie Matilda Chancellor  
 (a) Residence, No. 524 New Franklin Mo. St.  (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 31 - 1864  
 7. AGE YEARS 75 MONTHS 1 DAYS 29 IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
 OCCUPATION  
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. School teacher  
 9. Industry or business in which work was done, as saw mill, bank, etc. N.E. School  
 10. Date deceased last worked at this occupation (month and year) Sept 24, 1939 11. Total time (years) spent in this occupation 41 yrs  
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Howard Co., Mo.  
 FATHER  
 13. NAME Joseph Chancellor  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.  
 MOTHER  
 15. MAIDEN NAME Sarah Lee  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Howard Co., Mo.  
 17. INFORMANT Miss Ida Chancellor (ADDRESS) New Franklin, Mo.  
 18. BURIAL, CREMATION, OR REMOVAL PLACE Clarks Chapel DATE 10/3/39  
 19. FUNERAL DIRECTOR (NAME) C.S. Dunsen (ADDRESS) New Franklin, Mo.  
 20. FILED 10-3- 1939 Clara T. Landrum Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 29, 1939  
 22. I HEREBY CERTIFY, That I attended deceased from Sept 22, 1939, to Sept 30, 1939  
 I last saw her alive on Sept 30, 1939. Death is said to have occurred on the date stated above, at 9:40 p.m.  
 The principal cause of death and related causes of importance were as follows:  
Influenza  
 Date of onset 9-22-39  
 Other contributory causes of importance:  
Injury to Lumbar Vertebrae 9-24-39  
 Name of operation no Date of \_\_\_\_\_  
 What test confirmed diagnosis? Alcohol Was there an autopsy? No  
 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? No  
 If so, specify \_\_\_\_\_  
 (Signed) J. B. Fleet, M. D.  
 (Address) New Franklin, Mo.

MARGIN RESERVED FOR BINDING  
WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

V. S. NO. 2.  
30M-1-12-38  
I X16029

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

1942

RECEIVED  
District Health Officer No. 2  
District File Number  
Date Filed 10/9/39

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 H. L. Hall

Licensed Embalmer No. 3515

P. O. Address New Franklin, 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 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

32521  
Do not use this space.

1. PLACE OF DEATH  
 (a) County Howard Registration District No. 380  
 (b) Township New Franklin Primary Registration District No. 4224 Registered No. 23  
 (c) City New Franklin 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 Josie Matilda Chancellor  
 (a) Residence, No. \_\_\_\_\_ 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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (use the word) S

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.  
75 1 29

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)

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

MOTHER  
 15. MAIDEN NAME  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED \_\_\_\_\_, 19\_\_\_\_

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 30, 1939

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_.

I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.

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

Influenza  
194 B  
 Date of onset \_\_\_\_\_

Other contributory causes of importance:

Injury to lumbar vertebrae. Bladder paralysis. N. M. D.

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

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) J. B. Fleet, M. D.

(Address) New Franklin Mo

SUPPLEMENTARY

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.

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

