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MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

21933

State File No.

Registration District No. 400

Primary Registration District No. 555313

Registrar's No. 119

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Little Blue
(c) Name of hospital or institution Jb. Home
(If not in hospital or institution, write street number or location) 3
(d) Length of stay: In hospital or institution 3 days
In this community 74 yrs. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson
(c) City or town Independence
(If outside city or town limits, write "RURAL")
(d) Street No. R.R. # 5
(If rural, give location)
(e) If foreign born, how long in U. S. A.?

3. (a) PRINT FULL NAME Chemister Mr John

3. (b) If veteran, name war. (c) Social Security No.

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced

6. (b) Name of husband or wife (c) Age of husband or wife if alive years

7. Birth date of deceased 6 - 13 - 1864 (Month) (Day) (Year)

8. AGE: Years 76 Months 3 Days 3 hr. min.

9. Birthplace Sedalia Mo (City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

12. Name John Chemister

13. Birthplace Sedalia Mo (City, town, or county) (State or foreign country)

14. Maiden name Emma Platt

15. Birthplace Mo (City, town, or county) (State or foreign country)

16. (a) Informant Mrs M. C. Foster M.D. (b) Address Little Blue Mo

17. (a) Burial (b) Date thereof 6 19 40 (Ritual, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Kansas City

18. (a) Signature of funeral director C. S. Foster (b) Address 918 Broadway

19. (a) 6-16-40 (b) S. H. G. Brown (Date received by registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month June day 16 year 1940 hour 6 minute P.M.

21. I hereby certify that I attended the deceased from 13 1940 to June 16 1940 that I last saw him alive on June 16 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac Decomposition

Due to Ch. Myocarditis

Due to Ch. Hemiplegia

Other conditions Old Cerebral Hem. 6 Mo (Include pregnancy within 3 months of death)

Major findings: Of operations 93C Of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? 932

While at work? (Specify type of place) (Specify date of injury) M. C. Foster M.D. (M, F or other)

Address Little Blue Day Mo

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

June 16-40

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.....

Licensed Embalmer No.....

P. O. Address.....

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.