

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **34573**

NOV 12 1940
Registration District No. **222**

Primary Registration District No. **1002**

Registrar's No. **4089**

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: K. C. General Hospital No. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: 1 day In hospital or institution (Specify whether
In this community Life years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 6837 E. 14th St.
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

3. (a) PRINT FULL NAME DON CHRISMAN

3. (b) If veteran, name war No 3. (c) Social Security No. 494-16-3891

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

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

7. Birth date of deceased 20 10 17
(Month) (Day) (Year)

8. AGE: Years 23 Months 0 Days 14 If less than one day hr. min.

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

10. Usual occupation Laborer

11. Industry or business _____

12. Name Orville Lee Chrisman

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

14. Maiden name Ellie Mae Johnson

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

16. (a) Informant Mrs. Orville Chrisman

(b) Address 6837 E. 14th St.

17. (a) Buried (b) Date thereof 10 26 40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Floral Valley
18. (a) Signature of funeral director John D. Sheil
(b) Address 600 E. 14th St. K.C. Mo
19. (a) 10-25-40 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 24th
year 1940 hour 8 minute 10 A M.

21. I hereby certify that I attended the deceased from 10-23-40, 19____, to 10-24-40, 19____;
that I last saw him alive on 10-24-40, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death rhematic heart disease with mitral stenosis

Due to _____
Due to _____

Other conditions Chronic congestion of lungs and liver.
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____
Of autopsy See above

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? _____

While at work? _____ (Specify type of place) (e) Means of injury 1
23. Signature Dr. R. Thore (M. D. or other)
Address Med. Dir. K.C. Gen. Hospital Date signed _____

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

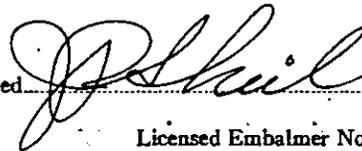
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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. 2635

P. O. Address K.C. 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.