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5-17-39  
X21402

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

6594

State File No. \_\_\_\_\_

REGISTRATION DISTRICT NO. 3

Primary Registration District No. 518 57

Registrar's No. \_\_\_\_\_

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

**1. PLACE OF DEATH:**

(a) County Carroll

(b) City or town Tiwa, Mo.  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
no. 1 Van Horn  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 62 years. years, months or days

**3. (a) PRINT FULL NAME** ALONZO CHEESMAN.

**8. (b) If veteran,** name war no.

**8. (c) Social Security** No. no.

**4. Sex** MALE

**5. Color or race** white

**6. (a) Single, widowed, married, divorced** MARRIED

**6. (b) Name of husband or wife** Ada Cheesman

**6. (c) Age of husband or wife if alive** 62 years

**7. Birth date of deceased** April 1, 1879  
(Month) (Day) (Year)

**8. AGE:**

Years	Months	Days	If less than one day
<u>61</u>	<u>62</u>	<u>10</u>	<u>18</u>
			hr. _____ min.

**9. Birthplace** Missouri (City, town, or county) D. (State or foreign country)

**10. Usual occupation** Farmers

**11. Industry or business** \_\_\_\_\_

**12. Name** John Cheesman

**13. Birthplace** Indiana (City, town, or county) (State or foreign country)

**14. Maiden name** Allen

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

**16. (a) Informant** Mrs. Alonzo Cheesman

**(b) Address** Tiwa, Mo.

**17. (a) Burial** (Burial, cremation, or removal)

**(b) Date thereof** \_\_\_\_\_ (Month) (Day) (Year)

**(c) Place: burial or cremation** Coloma

**18. (a) Signature of funeral director** E. A. Dickerson

**(b) Address** Boyard, Mo.

**19. (a) 2-3-41** (Date received local registrar)

**(b) [Signature]** (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Carroll

(c) City or town Rural (If outside city or town limits, write "RURAL")

(d) Street No. Rural (If rural, give location)

(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH:** Month Feb. day 20 year 1941 hour 7:00 AM minute \_\_\_\_\_ M.

**21. I hereby certify that I attended the deceased from** Jan. 5 1941 to Feb. 20 1941; that I last saw him alive on Jan. 20 1941 and that death occurred on the date and hour stated above.

Immediate cause of death Coccyx thrombosis

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

**PHYSICIAN**

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

Underlines the cause to which death should be charged statistically.

**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? 128 (Specify type of place)

While at work? \_\_\_\_\_ (a) Means of injury \_\_\_\_\_

**23. Signature** Dr. Everett L. Smith (M. D. or other) D.O.

Address Tiwa, Mo. Date signed Feb. 21, 41

RECEIVED  
District Health Officer No. 8,  
District File Number  
3-18-41  
Date Filed

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 *E. D. [Signature]*  
Licensed Embalmer No. 2534  
P. O. Address Boyerd 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.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

State File No. 6594

Registration District No. 133

Primary Registration District No. 5184

Registrar's No. \_\_\_\_\_

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

1. PLACE OF DEATH:

(a) County Carroll

(b) City or town Van Horn Twp  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: \_\_\_\_\_  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
years, months or days)

3. (a) PRINT FULL NAME Along Cheesman

3. (b) If veteran, name war \_\_\_\_\_ 3. (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 \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ years

7. Birth date of deceased Apr 1 1879  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
<u>61-62</u>	<u>10</u>	<u>18</u>		by _____ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name \_\_\_\_\_

{ 13. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

{ 14. Maiden name \_\_\_\_\_

{ 15. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_

(c) City or town \_\_\_\_\_ (If outside city or town limits write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

20. DATE OF DEATH: Month Feb day 20 year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

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? \_\_\_\_\_

(Specify type of place) \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature E. E. Smith (M. D. or other) \_\_\_\_\_  
Address Tuna Date signed \_\_\_\_\_

SUPPLEMENTARY

S-6594