

FILLED JUL 15 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

22068

State File No. _____

Registration District No. 1034

Primary Registration District No. 5631

Registrar's No. 2

1. PLACE OF DEATH:

(a) County Lawrence
(b) City or town Miller Mo. R.R.
(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 _____
In this community 2 years
years, months or days (Specify whether)

3. (a) PRINT FULL NAME William Floyd Chastain

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

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced single

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

7. Birth date of deceased 6-11-1920
(Month) (Day) (Year)

8. AGE: Years 21 Months _____ Days 5 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name William Chastain
13. Birthplace Laclede Co. Mo.
14. Maiden name Rhoda Ann Hick
15. Birthplace Wright Co. Mo.

16. (a) Informant Mrs Rhoda Chastain

(b) Address Miller Mo.

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director Monnie Deimon

(b) Address Miller Mo.

19. (a) June 20, 1941 (b) Alta Wilson
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Lawrence
(c) City or town Miller Mo. R.R.
(If outside city or town limit, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A.? ALL his life years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 16
year 1941 hour 7 minute 10 P. M.

21. I hereby certify that I attended the deceased from March 3, 1941 to June 16, 1941; that I last saw him alive on June 16, 1941; and that death occurred on the date and hour stated above.

Immediate cause of death Leukemic Leukemia Duration 8 mo.?

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

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? _____

430
While at work _____ (Specify type of place)
(e) Means of injury _____

23. Signature Lozeth Glover M.D. (M. D. or other) _____

Address Miller Mo. Date signed 7/1/41

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

55
0
0

RECEIVED

District Health Officer No. 6;

District File Number 741-1204

Date Filed JUL 12 1941

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. P. Seiman

Licensed Embalmer No. 3297

P. O. Address Miller 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.

Registration District No. 1054

Primary Registration District No. 5631

Registrar's No. _____

1. PLACE OF DEATH: Lawrence

(a) County _____

(b) City or town _____
(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 _____
years, months or days)

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) Citizen of foreign country _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME William Floyd Chastain

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 16
year 1941 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.

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced 1

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

7. Birth date of deceased: June 11 1926
(Month) (Day) (Year)

Immediate cause of death _____

Due to _____

Due to _____

8. AGE: Years _____ Months _____ Days _____ If less than one day _____ hr. _____ min.

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

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

10. Usual occupation W. A. Lubow

11. Industry or business _____

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)

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 _____

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof June 18-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) June 20-41 (b) Alta Wilson
(Date received local registrar) (Registrar's signature)

23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTARY

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

MOTHER FATHER

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

