

DEC 11 1942

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

Registration District No. 1

Primary Registration District No. 3000

Registrar's No. 294

1. PLACE OF DEATH:  
 (a) County Adair  
 (b) City or town Kirksville  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: CNH 4 Community Nursing Home  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 8 days (Specify whether  
 In this community All his life years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Missouri (b) County Adair  
 (c) City or town Kirksville  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 1401 N. Nelson (If rural, give location)  
 (e) Citizen of foreign country? no (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME John Avery Chaffy  
 (b) If veteran, name war \_\_\_\_\_ (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month Nov day 9  
 year 1942 hour 8 minute 25 P. M.  
 21. I hereby certify that I attended the deceased from 11/2/42  
 \_\_\_\_\_, 19\_\_\_\_, to 11/9/42, 19\_\_\_\_;  
 that I last saw him alive on 11/9/42, 19\_\_\_\_;  
 and that death occurred on the date and hour stated above.

4. Sex M. O 5. Color or race W.  
 6. (a) Single, widowed, married, divorced CO  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if  
 alive \_\_\_\_\_ years  
 7. Birth date of deceased April 27 1868  
 (Month) (Day) (Year)

Immediate cause of death Myocardial Failure Duration \_\_\_\_\_  
 Due to Cardiac Decompensation  
 Due to \_\_\_\_\_  
 Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_  
 Major findings: Of operations 95C 2  
 Of autopsy \_\_\_\_\_

8. AGE: Years 74 75 Months 6 Days 12 If less than one day  
 \_\_\_\_\_ hr. \_\_\_\_\_ min.  
 9. Birthplace Texas  
 (City, town, or county) (State or foreign country)  
 10. Usual occupation Farmer

MOTHER { 11. Industry or business \_\_\_\_\_  
 12. Name John C. Chaffy  
 13. Birthplace Dand, Ark 9 (City, town, or county) (State or foreign country)  
 14. Maiden name Felda Jones  
 15. Birthplace Ohio (City, town, or county) (State or foreign country)  
 16. (a) Informant Jos. H. Chaffy  
 (b) Address Des Moines, Iowa  
 17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/12/42  
 (Month) (Day) (Year)  
 (c) Place: burial or cremation Forest Park, Kirksville  
 18. (a) Signature of funeral director E. H. Brown  
 (b) Address Des Moines, Iowa  
 19. (a) 11/12/42 (Date received local registrar) (b) Mr. J. H. Wayne (Registrar's signature)

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?  
 While at work? \_\_\_\_\_ (Specify type of place)  
 (e) Means of injury \_\_\_\_\_  
 23. Signature Cather P. Barney (M. D. or other) D.O.  
 Address Kirksville, Mo Date signed 11/9/42

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

RECEIVED

District Health Officer No. 10

District File Number 12-42-4061

Date Filed Dec. - 10 - 1942

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, fact should be so stated above.