

S. No. 2  
M-9-4-41  
5-17-39  
X29482

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **21603**  
Registrar's No. **57**

FILED JUL 12 1943  
Registration District No. **755**

Primary Registration District No. **3127**

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

49  
6  
2

1. PLACE OF DEATH:  
(a) County Jasper  
(b) City or town Webb City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Jane Chinn Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1 day (Specify whether  
In this community 85 years (Specify whether  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Jasper  
(c) City or town Necke City  
(If outside city or town limits, write "RURAL")  
(d) Street No. General Delivery  
(If rural, give location)  
(e) Citizen of foreign country? No data (Yes or No)  
If yes, name country 0

3. (a) PRINT FULL NAME Oliver Chambers

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month June day 29  
year 1943 hour 7:30 minute A. M.

3. (b) If veteran, name war no data 3. (c) Social Security No. None

21. I hereby certify that I attended the deceased from  
June 28, 1943, to June 29, 1943.  
that I last saw him alive on June 28, 1943  
and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race W. 6. (a) ~~Single~~ widowed, married, divorced, 2

Immediate cause of death Chronic nephritis  
Duration unknown

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if  
alive \_\_\_\_\_ years  
7. Birth date of deceased. May no data 1858  
(Month) (Day) (Year)

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

Due to 69  
Due to \_\_\_\_\_

9. Birthplace No data no data  
(City, town, or county) (State or foreign country)

Other conditions Pellagra-malnutrition  
(Include pregnancy within 3 months of death)

10. Usual occupation Common Laborer

PHYSICIAN  
Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

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

MOTHER FATHER {  
12. Name No data  
13. Birthplace No data 9  
(City, town, or county) (State or foreign country)  
14. Maiden name No data  
15. Birthplace No data 9  
(City, town, or county) (State or foreign country)

16. (a) Informant Records  
(b) Address \_\_\_\_\_

17. (a) Burial (b) Date thereof 7/2/43  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Purcell Cemetery

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)

18. (a) Signature of funeral director Wedge Nelson  
(b) Address Webb City, Missouri  
19. (a) July 2, 1943 (b) Miss Miller  
(Date received local registrar) (Registrar's signature)

While at work \_\_\_\_\_ (c) Means of injury \_\_\_\_\_  
23. Signature Robert M. Ferguson (M. D. or other) MD  
Address Webb City, Missouri Date signed 7-2-43

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43-6-527

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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..... *C. W. Hedge* .....

Licensed Embalmer No. *2859* .....

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.**