

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 1049

Primary Registration District No. 3000

Registrar's No. 233

1. PLACE OF DEATH:

(a) County Adair

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

(c) Name of hospital or institution: X COS Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: 1 month
(Specify whether years, months or days)

In this community 1 month

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Marion

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

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

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

3. (a) PRINT FULL NAME BEULA ELIZABETH CHICKNER

3. (b) If veteran, name war ✓

3. (c) Social Security No. _____

4. Sex Female 5. Color or race W

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

6. (b) Name of husband or wife Cecil Chickner 6. (c) Age of husband or wife if alive 33 years

7. Birth date of deceased Aug 25 1911
(Month) (Day) (Year)

8. AGE: Years 31 Months 11 Days 17 If less than one day _____ hr. _____ min.

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

10. Usual occupation housewife

11. Industry or business _____

12. Name Harry Schapper

13. Birthplace Lewis Co. Missouri
(City, town or county) (State or foreign country)

14. Maiden name Stephens

15. Birthplace Lewis Co. Missouri
(City, town or county) (State or foreign country)

16. (a) Informant Cecil C. Chickner

(b) Address Marion Mo.

17. (a) Ferksville (b) Date thereof 8-15-1943
(Burial, cremation or other) (Month) (Day) (Year)

(c) Place: burial or cremation Durham Cemetery

18. (a) Signature of funeral director David J. Adams

(b) Address Ferksville Mo.

19. (a) 9/4/43 (b) Mrs. J. Wayne
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 17 year 1943 hour 7 minute 00 P.M.

21. I hereby certify that I attended the deceased from July 14 1943 to Aug 12 1943
that I last saw her alive on Aug 12 1943
and that death occurred on the date and hour stated above.

Immediate cause of death: Pulmonary Embolism

Due to following
Cesarian operation

Other conditions (Include pregnancy within 3 months of death) 1498

Major findings: Cesarian operation
Of operations _____
Of autopsy _____

Duration _____
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 J. H. Adams MD (M.D. or other) _____
Address Ferksville Date signed 8/12/43

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

MOTHER FATHER

1049

RECEIVED**District Health Officer No. 10**District File Number 9-43-1500Date Filed SEP 10 1943**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 *A. J. Brown*Licensed Embalmer No. 1407P. O. Address Kissville, 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, fact should be so stated above.**