

FILED FEB 27 1944

Registration District No. 2

Primary Registration District No. 2007

Registrar's No. 5

1. PLACE OF DEATH:

(a) County Butler  
(b) City or town Pope's Bluff, Mo.  
(c) Name of hospital or institution:  
Tracy Hill Hosp.  
(d) Length of stay: In hospital or institution 5 days  
In this community 5 years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Arkansas (b) County Clay  
(c) City or town Cassing, Arkansas Rt 2  
(d) Street No. \_\_\_\_\_  
(e) Citizen of foreign country? \_\_\_\_\_  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Edwin Ray Chisolm

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. no.

4. Sex male 5. Color & race white 6. (a) Single, widowed, married, divorced married  
6. (b) Name of husband or wife Edna Chisolm 6. (c) Age of husband or wife if alive 40 years  
7. Birth date of deceased Aug 13

8. AGE: Years 46 Months 4 Days 18 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation farm work

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

12. Name John Chisolm  
13. Birthplace Mississippi  
14. Maiden name Fred Culbert  
15. Birthplace Mississippi

16. (a) Informant Clara Ruff

(b) Address Cassing Ark Rt 2

17. (a) Burial (b) Date thereof 1-3-44  
(c) Place: burial or cremation Post Oak, Mo

18. (a) Signature of funeral director H. J. Lutz

(b) Address Cassing, Arkansas

19. (a) 1-5-44 (b) Bille Turner  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 1st year 1944 hour 10 minute 30 A.M.

21. I hereby certify that I attended the deceased from Dec. 27 1943 to Jan. 1 1944  
that I last saw him alive on Dec. 27 and that death occurred on the date and hour stated above.

Immediate cause of death acute cardiac failure  
Due to Pericarditis  
Due to acute Bacterial Endocarditis

Duration  
2 days  
5 days  
14 days  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

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? \_\_\_\_\_  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

23. Signature [Signature] (M. D. or other) \_\_\_\_\_  
Address Pope's Bluff Mo Date signed 1/3/44

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

MOTHER FATHER

DEC 8 1948  
DEC 11 1948

RECEIVED

District Health Office No. 2,

District File Number 144-174

Date Filed 1-25-44

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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.....

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.**

FILED FEB 27 1944

Registration District No. 42

Primary Registration District No. 2007

Registrar's No. 5

1. PLACE OF DEATH:

(a) County Butler  
 (b) City or town Poplar Bluff, Mo.  
(If outside city or town limits, write "RURAL" in place of town limits)  
 (c) Name of hospital or institution  
Missouri Hospital  
(If not in hospital or institution, write street number & location)  
 (d) Length of stay: In hospital or institution 5 days  
(Specify whether in this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cedar  
 (c) City or town Cassings, Arkansas St 2  
(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 \_\_\_\_\_

1. (a) PRINT FULL NAME Elvin Ray Chisolm  
Elvin Ray Chisolm

1. (b) If veteran, no 3. (i) Social Security No. 200

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

6. (b) Name of husband or wife Edna Chisolm 6. (c) Age of husband or wife if alive 40<sup>36</sup> years

7. Birth date of deceased Aug 13 1897  
(Month) (Day) (Year)

AGE:	Years	Months	Days	If less than one day
	<u>46</u>	<u>4</u>	<u>18</u>	hr. _____ min. _____

9. Birthplace DeKalb, Kemper County, Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Farm work Owner

11. Industry or business Wesley Chisolm

12. Name John Chisolm

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

14. Maiden name Isabella Louiza Calvert

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

16. (a) Informant Clara Ruff

(b) Address Cassings Ark St 2

17. (a) Burial (b) Date thereof 1-3-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Post Oak, Mo

18. (a) Signature of funeral director H. H. [unclear]

(b) Address Cassings, Arkansas

19. (a) 1-5-44 (b) Belle Turner  
(Date received from registrars) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 1st year 1944 hour 10 minute 50 A.M.

21. I hereby certify that I attended the deceased from Dec. 27 1943 to Jan. 1 1944 that I last saw him alive on Dec. 27 1943 and that death occurred on the date and hour stated above.

Immediate cause of death Acute Cardiac Failure Duration 2 days  
 Due to Pericarditis 5 days  
 Due to Acute Dehydrated Endocarditis 14 days

Other conditions 91a  
(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? \_\_\_\_\_

23. Signature [unclear] (M. D. or D.O.)  
 Address Poplar Bluff, Mo Date signed 1/3/44

Items #3, 6b, c, 7, 9, 10, 12, 14 amended by affidavit of daughter of deceased 10-7-93