S. No. 2
M—8-43
v. 5-17-39
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 7 1945

Registration District No. 141

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 3025

State File No. 6267

Registrar's No. 23

1. PLACE OF DEATH:

(a) County Howell

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

(c) Name of hospital or institution: Ingold Rest Home 4
(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 Mo (b) County Howell

(c) City or town West Plains 46
(If outside city or town limits, write "RURAL")

(d) Street No. RFD 0
(If rural, give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country 0

3. (a) PRINT FULL NAME Chas E. Denman

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced ? 9

6. (b) Name of husband or wife .....

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

7. Birth date of deceased unk (Month) (Day) (Year)

8. AGE: Years About 86 Months 4 Days 13 — If less than one day ..... hr. ..... min.

9. Birthplace England (City, town, or county) 4 (State or foreign country)

10. Usual occupation Farming

11. Industry or business .....

FATHER
12. Name unk
13. Birthplace " (City, town, or county) 9 (State or foreign country)

MOTHER
14. Maiden name .....
15. Birthplace " (City, town, or county) 9 (State or foreign country)

16. (a) Informant Mrs Lottie Ingold

(b) Address West Plains Mo

17. (a) B (Burial, cremation, or removal) (b) Date thereof Nov. 15-44 (Month) (Day) (Year)

(c) Place: burial or cremation West Plains

18. (a) Signature of funeral director Robertson

(b) Address West Plains Mo

19. (a) 2/15-45 (Date received local registrar) (b) Paul Harlin (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 13 year 1944 hour 5 minute 30 P. M.

21. I hereby certify that I attended the deceased from 8-19-, 1944, to 11-13-, 1944 that I last saw him alive on 10-30-, 1944; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Chronic Cardiac Valvular disease Mitral insufficiency	
Due to	
Due to	
Other conditions General Arteriosclerosis (Include pregnancy within 3 months of death)	
Major findings: Of operations 92 d	
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? ..... (Specify type of place)

While at work? ..... (e) Means of injury .....

23. Signature E. C. Bohrer (M. D. or other) MD

Address West Plains Mo Date signed 11-30-44

B Bohrer

1125

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 5,
District File Number 345195
Date Filed 12-5-45

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.