

No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6475

State File No. _____

FILED MAR 14 1945
Registration District No. 170

Primary Registration District No. 5628

Registrar's No. _____

1. PLACE OF DEATH:

(a) County LACLEDE

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

(c) Name of hospital or institution:
PLATO RT 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community ALWAYS
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County LACLEDE 53

(c) City or town RURAL 1
(If outside city or town limits, write "RURAL") 0

(d) Street No. PLATO RT
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No) 1
If yes, name country _____

3. (a) PRINT FULL NAME ROBT. C. CHATHAM

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month FEB day 27
year 1945 hour 10 minute 4 M.

21. I hereby certify that I attended the deceased from March 1943 to 1945
that I last saw him alive on April October 1944
and that death occurred on the date and hour stated above.

4. Sex M C 5. Color or race W

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

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

6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased FEB 3 1870
(Month) (Day) (Year)

Immediate cause of death Cardiac failure Duration _____

8. AGE: Years Months Days If less than one day

75 - 24 hr. min.

Due to Infirmities of life

Due to _____

9. Birthplace LACLEDE CO MO 1
(City, town, or county) (State or foreign country)

10. Usual occupation FARMER

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

Major findings:
Of operations _____

Of autopsy _____

11. Industry or business _____

12. Name J. H. CHATHAM

13. Birthplace BLOOMINGTON ILL 1
(City, town, or county) (State or foreign country)

14. Maiden name LOU ELLEN ALLEN

15. Birthplace BLOOMINGTON ILL 1
(City, town, or county) (State or foreign country)

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 _____

16. (a) Informant Leonard Chatham

(b) Address LEBANON MO

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3-2-45
(Month) (Day) (Year)

(c) Place: burial or cremation M. Cinnis Cem.

23. Signature R. S. Saunders (M. D. or other) 2 20
Address Lebanon, Mo. Date signed 3/1/45

18. (a) Signature of funeral director PALMERS

(b) Address LEBANON MO

19. (a) 3-3-45 (Date received local registrar) (b) Shane Robin (Registrar's signature)

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

MOTHER FATHER

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

PHYSICIAN Underline the cause to which death should be charged statistically.

Received

Laclede County Health Unit

File No. 2-45-71

Date Filed 3/13/45

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.....

R. D. Bahner

Licensed Embalmer No. 1161

P. O. Address Limon

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. March
Registrar's No. _____

Registration District No. 170 Primary Registration District No. 5628

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

1. PLACE OF DEATH:
(a) County Laclede
(b) City Grand Passendale Ferry
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(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 (Specify whether _____)

3. (a) PRINT FULL NAME Robt C. Chatham
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 M
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if _____ years

7. Birth date of deceased Feb. 3
(Month) (Day) (Year)

8. AGE: Years 75 Months _____ Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State _____ (b) County _____
(c) City or town _____ (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 _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month _____ day _____
year _____ hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____, 19____;
that I last saw him/her alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to Chronic Myocarditis
Due to 93d
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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 C
23. Signature _____ (M. D. or other) _____
Date signed _____

6475

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