

No. 2
8-43
7-39
X37823

FILED FEB 15 1946

Registration District No. **29**

Primary Registration District No. **5761**

Registrar's No. **6**

1. PLACE OF DEATH:

(a) County Marion Co.
 (b) City or town Laurel, Rural
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Marion Co. Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution about 2 yrs
 (Specify whether years, months or days) about 73 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Marion **64**
 (c) City or town Hannibal **3**
 (If outside city or town limits, write "RURAL")
 (d) Street No. Not Known **4**
 (If rural, give location)
 (e) Citizen of foreign country? No. (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME JAMES H. CHATTIN

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

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

6. (b) Name of husband or wife Emma Chattin 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased 3 18 1872
 (Month) (Day) (Year)

8. AGE: Years 73 Months 10 Days 2 If less than one day hr. _____ min. _____

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

10. Usual occupation Carpenter

11. Industry or business _____

12. Name James Chattin

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

14. Maiden name Emma Carpenter

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

16. (a) Informant Hospital records

(b) Address Marion Co. Mo.

17. (a) Downing Mo. (b) Date thereof 1 22-46
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Downing Cemetery

18. (a) Signature of funeral director A. M. Sprague

(b) Address Palmyra Mo.

19. (a) Jan. 21, 1946 (b) Laurie Boone
 (Date received local registrar) (Registrar's signature) Deputy

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 20
 year 1946 hour 8 minute 15 A: M.

21. I hereby certify that I attended the deceased from Sept - 1, 1945 to Jan. 20, 1946
 that I last saw him alive on Jan. 19, 1946
 and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial Degeneration **2 years**
 Duration _____

Due to Arteriosclerosis

Due to _____

Other conditions (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? _____

While at work _____ (Specify type of place) Means of injury _____

23. Signature [Signature] (M. D. or other) _____
 Address Hannibal Date signed 1-21-46

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

189

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. M. Sprague
Licensed Embalmer No. 999
P. O. Address Palmyra 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Feb
Registrar's No. 6

Registration District No. 208 Primary Registration District No. 5761

1. PLACE OF DEATH:

(a) County Marion
(b) City or town Rural Liberty Twp
(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 James H. Chatterin
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 Widowed
6. (b) Name of husband or wife Elizabeth 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Mar (Month) 18 (Day) 19 (Year)

8. AGE: Years 73 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____

19. (a) _____ (Date received local registrar) (b) [Signature] (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 1946 Hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Duration

Due to _____

Due to _____

Other conditions _____ (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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

1585

SUPPLEMENTARY

3299