

S. No. 2  
I-5-42  
5-17-39  
X32873

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

9129

**FILED** APR 12 1946

**STANDARD CERTIFICATE OF DEATH**

State File No. ....

Registration District No. 122

Primary Registration District No. 5453

Registrar's No. 4

**1. PLACE OF DEATH:**

(a) County Greene  
(b) City or town Brookline  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 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 3 years years, months or days

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Greene  
(c) City or town Brookline Mo  
(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 Robert Allen Chilcott

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

4. Sex Male 5. Color or race W 6. (a) Single, widowed, married, divorced 0

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased. 11 (Month) 11 (Day) 1936 (Year)

8. AGE: Years 9 Months 4 Days 9 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Greene Co MO (City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

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

MOTHER FATHER { 12. Name Frank Chilcott  
13. Birthplace MO (City, town, or county) (State or foreign country)  
14. Maiden name Heller Bernie  
15. Birthplace South Decatur (City, town, or county) (State or foreign country)

16. (a) Informant Frank Chilcott

(b) Address Brookline MO

17. (a) Burial (b) Date thereof 3 29-46 (Month) (Day) (Year)

(c) Place: burial or cremation Brookline MO

18. (a) Signature of funeral director Morris L Leimda

(b) Address Ash Grove MO

19. (a) Mar 21-1946 (Date received local registrar) (b) Flourance Britain (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month March day 20 year 1946 hour 7 minute 25 A.M.

21. I hereby certify that I attended the deceased from March 15 1946 to March 20 1946 that I last saw him alive on March 19 and that death occurred on the date and hour stated above.

Immediate cause of death Measles Duration 5 days

Due to Bronchopneumonia 24 hrs

Due to Diabetes Mellitus 5 yrs

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations 41 Of autopsy \_\_\_\_\_ 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. M. LeCompte Md. (M. D. or other) Address Brookline Mo Date signed 3/21-46

105

(Licensed Embalmer's Statement on Reverse Side)

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

8056

RECEIVED  
County Health Office,  
County File Number 46-4-43  
D. O. File 411-46

**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 Maude O Morris  
Licensed Embalmer No. 2055  
P. O. Address Ash Grove 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.**