

No. 2
-12-45
-17-39
I X47070

FILED OCT 8 1947

Registration District No. **38**

Primary Registration District No. **3006**

Registrar's No. **259**

1. PLACE OF DEATH:

(a) County **Boone**

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

(c) Name of hospital or institution:
The Ellis Fischel State Cancer Hosp.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **105 days**
(Specify whether years, months or days)

In this community **same**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Lawrence**

(c) City or town **Wiceson**
(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 **Allan Chastain**

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 **married**

6. (b) Name of husband or wife **Pearl Chastain**

6. (c) Age of husband or wife if alive **31** years

7. Birth date of deceased **July 22 1909**
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
36	2	10	hr. _____ min. _____

9. Birthplace **Lawrence County Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Laborer**

11. Industry or business _____

MOTHER, FATHER

12. Name **Wilford Chastain**

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

14. Maiden name **DK**

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

16. (a) Informant **Ellis Fischel Hospital Records**

(b) Address **Columbia, Mo.**

17. (a) **Burial** (b) Date thereof **Oct 5 1947**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Wiceson Mo**

18. (a) Signature of funeral director **R. Palmer**

(b) Address **Columbia**

19. (a) **10-3-47** (b) **Mrs R.E. Palmer**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct.** day **2**
year **1947** hour **9:30** minute **pm**

21. I hereby certify that I attended the deceased from **6/19/1947** to **10/2/1947**
that I last saw him alive on **10/2/47** and that death occurred on the date and hour stated above.

Immediate cause of death **Cardiac failure and acute gastric dilatation**

Due to **acute gastric dilatation**

Due to **Seminoma with metastases**

Other conditions **metastases**
(Include pregnancy within 3 months of death)

Major findings:
Of operations **None**

Of autopsy **Absent**

Duration **1 day**

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 **Chas. O. Palmer** (M. D. or other) _____

Address **Mo. State Cancer Hosp** Date signed _____

Oct 3, 1947

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

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed 10/17/47

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, by
....., Registered Apprentice No.
working under my personal supervision.

Signed Lyman H. Sprinkle
Licensed Embalmer No. 4013
P. O. Address Columbia, 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.