

Health, Welfare, Public Service
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 ATTORNEY GENERAL
 Director, Coroner, etc. must use only standard forms prepared by the State Health Department. Coroner cannot certify to a death due to natural causes. Diseases in Part I must be casually related. USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED AUG 12 1957

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

24138
 STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 792

1. PLACE OF DEATH a. COUNTY GREENE				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO. b. COUNTY Cedar			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN SPRINGFIELD		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN STOCKTON		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BAPTIST			Length of stay in lb	d. STREET ADDRESS (If outside, give location)			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First MIDDLE LAST WOODROW CHASTAIN				4. DATE OF DEATH Month Day Year AUG. 7, 1957			
5. SEX M. <input checked="" type="checkbox"/>	6. COLOR OR RACE W. <input checked="" type="checkbox"/>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY 11, 1914		9. AGE (In years last birthday) 43	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		10b. KIND OF BUSINESS OR INDUSTRY FARM EQUIPMENT		11. BIRTHPLACE (City and state or country) CLEVER, MO.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME WILLIAM CHASTAIN				14. MOTHER'S MAIDEN NAME ALICE LEONARD			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address MRS. DEMA CHASTAIN STOCKTON, MO.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chronic Congestive Heart Failure</i> <i>Cremia</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Hypertensive Cardiovascular Disease</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i> <i>2 mo.</i> <i>1 yr</i>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE			
21. I attended the deceased from <i>July 10, 1957</i> to <i>Aug 7, 1957</i> and last saw <i>him</i> alive on <i>Aug 7, 1957</i> . Death occurred at <i>4:55 PM</i> on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <i>James T. Good M.D.</i>				22b. ADDRESS <i>Springfield, Mo</i>		22c. DATE SIGNED <i>8-8-57</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE <i>AUG. 10, '57</i>	23c. NAME OF CEMETERY OR CREMATORY <i>STOCKTON CEM.</i>		23d. LOCATION (City, town, or county) (State) <i>STOCKTON, MO.</i>		
24. FUNERAL DIRECTOR CANTLON			ADDRESS STOCKTON, MO.		25. DATE RECD. BY LOCAL REG. <i>8-9-57</i>	26. REGISTRAR'S SIGNATURE <i>Edith Williamson</i>	

AUG 26 1957

AUG 7 1958

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, Student Embalmer No. working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *H. S. McCann*.....

Licensed Embalmer No. *24*

P. O. Address *Springfield*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.