

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-021996

FILED VS JUN 8 1960

Registration District No. 333

Primary Registration District No. 3074

Registrar's No. 137

STATE FILE NUMBER

INDEXED

| | | | | | | | |
|--|--|---|--|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY Scott | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Scott | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) Sikeston | | Length of stay in Tb 1 day | | c. CITY OR TOWN Sikeston | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Mo. Delta Comm. Hospital | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 613 Taylor St. | | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) ROBERT HAROLD ROBERT CHEWNING | | | | 4. DATE OF DEATH Month 5 Day 28 Year 1960 | | | |
| 5. SEX Male | 6. COLOR OR RACE Caucasian | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH 2-25-1912 | 9. AGE (last birthday) 48 | IF UNDER 1 YEAR Months 3 Days 3 | IF UNDER 24 HR Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farm laborer | | | 10b. KIND OF BUSINESS OR INDUSTRY Agriculture | | 11. BIRTHPLACE (City and state or country) Chaffee, Missouri | | 12. CITIZEN OF WHAT COUNTRY USA |
| 13a. FATHER'S NAME James Chewning | | | 13b. MOTHER'S MAIDEN NAME Mary Jane Phelps | | | 14. NAME OF HUSBAND OR WIFE -- | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No. | | 16. SOCIAL SECURITY NO. 491 18 4260 | | 17. INFORMANT 613 Taylor St. Mrs. June C. Cope Sikeston, 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) Cerebral of Liver | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 years |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Encephalitis - Senes Anemia | | | | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20a. ACCIDENT <input type="checkbox"/> | SUICIDE <input type="checkbox"/> | HOMICIDE <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 _____ 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 22-Nov-59 to 28-May-60 and last saw ^{her} him alive on 28-May-60 Death occurred at 8:20 A.M. on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE Ed. Phoynton M.D. (Degree or title) | | | | 22b. ADDRESS Sikeston, Mo. | | 22c. DATE SIGNED 2 June-60 (State) | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE May 30, 1960 | 23c. NAME OF CEMETERY OR CREMATORY Pollard Cemetery | | 23d. LOCATION (City, town, or county) Benton, Mo. (5 mi. SE) | | | |
| 24. FUNERAL DIRECTOR Edward E. Nunnelee Nunnelee Funeral Chapel, Sikeston, Mo. | | | 25. DATE RECD. BY LOCAL REG. June 4-60 | | 26. REGISTRAR'S SIGNATURE Mrs. Callie Hunter | | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

(Signed Embalmer's Statement on Reverse Side)

FEB 20 1961

EST. 1912

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Edward E. Hunsicker

Licensed Embalmer No. 4164

P. O. Address Sikeston, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so 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.