

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

65-030539

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 337 Primary Registration District No. 6128 Registrar's No. 280

VS 300
Rev. 4/59

1 1010
2 1010
3
4 0
5 1
6
7 0
8 2
9 420.1
10
11
12 90-2
13 1-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Shannon</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Shannon</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Eminence</u>		Length of stay in 1b	c. CITY OR TOWN <u>Round Springs</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Round Springs</u>	
3. NAME OF DECEASED (Type or print) First <u>Woodward</u> Middle <u>Earl</u> Last <u>Chilton</u>			4. DATE OF DEATH Month <u>July</u> Day <u>11</u> Year <u>1965</u>		
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>7/7/01</u>	9. AGE (last birthday) <u>64</u>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Park Supt.</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Eminence, Mo.</u>	
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>Charles O. Chilton</u>		13b. MOTHER'S MAIDEN NAME <u>Blanche Woodward</u>	
14. NAME OF HUSBAND OR WIFE <u>Virginia B. Chilton</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Yes</u>	
17. INFORMANT <u>Virginia Chilton Round Springs Mo</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u>		INTERVAL BETWEEN ONSET AND DEATH <u>30 SEC.</u>	
DUE TO (b) <u>CORONARY THROMBOSIS</u>		DUE TO (c) _____		1 MIN.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)				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 <u>ON 7/11/65</u> to _____ and last saw him alive on <u>7/10/65</u> Death occurred at <u>11:30 A.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Denton Wilson, D.O.</u>			22b. ADDRESS <u>Eminence, Mo.</u>		22c. DATE SIGNED <u>7/14/65</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>7/13/65</u>	23c. NAME OF CEMETERY OR CREMATORY <u>New City Cem.</u>		23d. LOCATION (City, town, or county) <u>Eminence, Mo.</u>
24. FUNERAL DIRECTOR <u>Duncan Funeral Home Mtn. View, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>7-22-1965</u>		26. REGISTRAR'S SIGNATURE <u>Robert Green</u>

USE BLACK INK OR TYPEWRITER RIBBON

AUG 5 1965

Estimable Mortician

THORNTON
INFARCTION

PHYSICIAN
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 Charles D. Cartain

Licensed Embalmer No. 5107
P. O. Address Spring Hill, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.

11/10/17

11/10/17