MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1 PLACE OF DEATH

County .....

Township ..... or Village ..... or City St Louis (NO. City Hospital Ward)

Registration District No. 791 File No. 30473

Primary Registration District No. 1003 Registered No. 8331

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Sam Chambers

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE Colored

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Single

6 DATE OF BIRTH March 12 1879 (Month) (Day) (Year)

7 AGE 39 yrs. 5 mos. 20 ds. If LESS than 1 day, ...hrs. or ....min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry business, or establishment in which employed (or employer) Day

9 BIRTHPLACE (City or town, State or foreign country) Tennessee

PARENTS

10 NAME OF FATHER Dundy Chambers

11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Tennessee

12 MAIDEN NAME OF MOTHER Emmeline Parmer

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Tennessee

14 THE ABOVE is true to the best of my knowledge. Wm Thom

(Informant) E Ronan

(Address) City Hospital

15 Filed SEP -3 1918 Mark Starkloff Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 1 1918 (Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Aug 29 1918 to Sept 1 1918 that I last saw him alive on Sept 1 1918 and that death occurred, on the date stated above, at 4 a.m.

The CAUSE OF DEATH* was as follows:

Chronic valvular disease aortic insufficiency

24h

24A No (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Syphilis

(Duration) ....yrs. ....mos. ....ds.

(Signed) Emil Ostry M. D.

Sept 1 1918 (Address) City Hospital

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ....yrs. ....mos. 3 ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted if not at place of death? ....

Former or usual residence 311 Sidney.

19 PLACE OF BURIAL OR REMOVAL Greenwood

DATE OF BURIAL 9/5 1918

20 UNDERTAKER Gates-Manuel

ADDRESS 4107 Finney

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1 PLACE OF DEATH

County .....

Township ..... Registration District No. ..... File No. .....
or
Village ..... Primary Registration District No. ..... Registered No. .....
or
City ..... (NO. ....., ... St.; ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

6 DATE OF BIRTH

..... (Month) ..... (Day) ....., 1..... (Year)

7 AGE

..... yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry business, or establishment in which employed (or employer) .....

9 BIRTHPLACE
(City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER
(City or town, State or foreign country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed ....., 191....., ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

..... (Month) ..... (Day) ....., 191..... (Year)

17 I HEREBY CERTIFY, that I attended deceased from ....., 191....., to ....., 191.....

that I last saw h..... alive on ....., 191.....

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

....., 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ....., 191.....
20 UNDERTAKER	ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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Chambro