

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

32263

1. PLACE OF DEATH
 County Jackson Registration District No. 399 File No. 1234
 Township Raw Primary Registration District No. 1092 Registered No. _____
 City Kansas City (No. St. Joseph Hospital) St. _____ Ward _____
 2. FULL NAME Marshall Pine Chambers
 (a) Residence No. 1812 Lister St. _____ Ward _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) widowers

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 8, 1846

7. AGE. YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
75 1 26

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Carpenter
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Harpers Ferry West Va.
 (STATE OR COUNTRY)

10. NAME OF FATHER Jno D. Chambers

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Harpers Ferry
 (STATE OR COUNTRY) West Virginia

12. MAIDEN NAME OF MOTHER Elizabeth Cov.

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Harpers Ferry
 (STATE OR COUNTRY) West Virginia

14. INFORMANT W. Donald F. Chambers
 (Address) 2345 Celis St

15. FILED 19 1921 M. M. Crowe
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 4, 1921

17. I HEREBY CERTIFY, That I attended deceased from Dec 3 1921, to Dec 4 1921 that I last saw him alive on Dec 4 1921, and that death occurred, on the date stated above, at 9:45 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

uraemia

CONTRIBUTORY (SECONDARY) Eularche prostatic
 (duration) _____ yrs. _____ mos. 1 ds.

18. WHERE WAS DISEASE CONTRACTED _____

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? none
 (Signed) Pro Rosemeyer, M. D.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Mount Washington DATE OF BURIAL 12/6 1921

20. UNDERTAKER Oylar Bros. ADDRESS K. C. 224

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.

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

