

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

Do not use this space.

36744

1. PLACE OF DEATH

County Darwin
Township Gallatin
City Gallatin

Registration District No. 250
Primary Registration District No. 4150

File No. 555
Registered No. 555
St. _____ Ward _____

2. FULL NAME

(a) Residence No. _____ 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) married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept. 9-1857

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>72</u>	<u>2</u>	<u>14</u>	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work stock shaffer
(b) General nature of industry, business, or establishment in which employed (or employer) retired 20 years
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Piscataway, Ill.
(STATE OR COUNTRY) _____

10. NAME OF FATHER Ebenezer Chamberlain

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Vermont
(STATE OR COUNTRY) _____

12. MAIDEN NAME OF MOTHER Elizabeth Boyd

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Windsor, Vt.
(STATE OR COUNTRY) _____

14. INFORMANT Boyd Chamberlain
(Address) Gallatin, Miss.

15. FILED 9/30 1929 P. E. Gardner
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov. 23 1929

17. I HEREBY CERTIFY, That I attended deceased from Nov. 20 1929, to Nov. 23 1929 that I last saw him alive on Nov. 23 1929 and that death occurred, on the date stated above, at 5:30 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

92C
112
Myocarditis chr
(duration) 10 yrs. mos. ds.
CONTRIBUTORY Asthma, chronic
(SECONDARY) (duration) 60 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED? 92C
IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) G. A. Smith, M. D.

11/25 1929 (Address) Gallatin Mo

*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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Brown DATE OF BURIAL 11/25 1929

20. UNDERTAKER H. U. Hays ADDRESS Gallatin

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. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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