

MAY 27 1930

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

13148

1. PLACE OF DEATH

County.....Lafayette.....

Registration District No. H 60

Township.....Lafayette.....

Primary Registration District No. H 274

City.....Higginsville, (No.....)

File No.....

Registered No. 38

St.....Ward.....

2. FULL NAME

Robert Lewis Chamblin

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 1st 1854

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day,hrs. ormin.
	75	10	17	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....Retired Farmer

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

(c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN).....Rose Hill Mo.

(STATE OR COUNTRY) Johnson Co.

10. NAME OF FATHER Coleman E. Chamblin

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

12. MAIDEN NAME OF MOTHER Eliza Lovering

13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....St Louis.....
(STATE OR COUNTRY)

14. INFORMANT Coleman Chamblin

(Address) Higginsville, Mo.

15. FILED 4-18-30 Jessi P Porter

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 17 1930

17. I HEREBY CERTIFY, That I attended deceased from April 17 1930, to April 17 1930, that I last saw him alive on April 17 1930, and that death occurred, on the date stated above, at 12:30 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Influenza

CONTRIBUTORY (SECONDARY) 11B (duration) yrs. mos. 17 ds.

CONTRIBUTORY (SECONDARY) 11B (duration) yrs. mos. 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?

(Signed) W. G. Webb, M. D.

April 18, 1930 (Address) Higginsville

*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

DATE OF BURIAL

City Cemetary

April 19 1930

20. UNDERTAKER

ADDRESS

Higginsville, Mo.

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 FOR VEST, WITH PENCIL, ON REVERSE SIDE.

