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

Do not use this space.

25624

1. PLACE OF DEATH
County Stoddard
Township Elk.
City ..... (No. ..... St. ..... Ward)

Registration District No. 834
Primary Registration District No. 6100

File No. .....
Registered No. 47.

2. FULL NAME Veta Ilene Chamberlain -

(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 F.

4. COLOR OR RACE W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word) ✓

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 7-31-30

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, 4 hrs. or ..... min.
✓	✓	✓	

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

9. BIRTHPLACE (CITY OR TOWN) Parma Ro 1
(STATE OR COUNTRY) Mo.

PARENTS

10. NAME OF FATHER Mkmark
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Tonetha Jordan Chamberlain
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Sikeston
(STATE OR COUNTRY) Mo

14. INFORMANT Mrs W B Chamberlain
(Address) Parma. Mo

15. FILED 8-1-, 1930 J. P. Brandon REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 31- 1930

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19..... that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at 1130 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Premature Birth

159 (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED? 1610

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) J. P. Brandon, M. D.

, 19 (Address) Essex.

*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 At home

DATE OF BURIAL 7-31 1930

20. UNDERTAKER None.

ADDRESS

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.