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

Do not use this space.

5415
2

1. PLACE OF DEATH

64 County: Marion — Registration District No. 552
Township: Warren — Primary Registration District No. 5745
City ..... (No. ..... St. ..... Ward)

File No. 2
Registered No. .....

2. FULL NAME: Ralph Leon 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.

MAR 24 1932

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Male	White	single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Apr 1 - 1928

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	3	10	24	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: none

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

(c) Name of employer: .....

9. BIRTHPLACE (CITY OR TOWN) ..... (STATE OR COUNTRY): Marion Co. Mo.

PARENTS

10. NAME OF FATHER: Wm Chamberlain

11. BIRTHPLACE OF FATHER (CITY OR TOWN) ..... (STATE OR COUNTRY): Marion Co. Mo.

12. MAIDEN NAME OF MOTHER: Arta Brumer

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ..... (STATE OR COUNTRY): Clark Co. Mo

14. INFORMANT: Wm Chamberlain
(Address): Emden Mo.

15. FILED: Mar 8, 1932. Mrs Otta V. Wagner, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Feb - 25 - 1932

17. I HEREBY CERTIFY, That I attended deceased from Feb 17, 1932, to Feb 25, 1932, that I last saw him alive on Feb 24, 1932, and that death occurred, on the date stated above, at 4:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Whooping Cough 9 mos
10 yr
(duration) ..... yrs. ..... mos. 15 ds.

CONTRIBUTORY (SECONDARY): Bronchopneumonia
(duration) ..... yrs. ..... mos. 11 ds.

18. WHERE WAS DISEASE CONTRACTED: (1)
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) H. Ritt Rhodes, M. D
, 19 (Address) Philadelphia 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: Emden Cemetery — DATE OF BURIAL: Feb. 26 - 1932

20. UNDERTAKER: J W Thompson Son — ADDRESS: Shelbyville 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 PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD