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

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

Do not use this space.

17543

File No. .....

Registered No. 4455

1. PLACE OF DEATH

County ..... Registration District No. 1000

Township ..... Primary Registration District No. .....

City St. Louis (No. 4615 Lindell Blvd. ..... St. ..... Ward)

2. FULL NAME Margaret Chambers

(a) Residence, No. 9711 Lackland St., 12 Ward. St. Louis Co. Mo.
(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*): Single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) March 12 1913

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
19	1	24	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housemaid

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. 4615 Lindell 344

10. Date deceased last worked at this occupation (month and year) May 7 1932

11. Total time (years) spent in this occupation 5 yr

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Louis Mo

FATHER

13. NAME Lafe D. Chambers

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) California U.S.

MOTHER

15. MAIDEN NAME Margaret Chambers

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) California U.S.

17. INFORMANT (ADDRESS) Lafe Chambers 9711 Lackland ave

18. BURIAL, CREMATION, OR REMOVAL
PLACE Val Hill DATE May 9 1932

19. UNDERTAKER (ADDRESS) Baumann Bros. Overland Mo

20. FILED ..... 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 6 1932

22. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....

I last saw h..... alive on ..... 19..... Death is said to have occurred on the date stated above, at 9:40 a.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Shock & Injuries (Fractured Skull)	
Haemorrhage of Brain	
Fall from Window	
Accident	

Other contributory causes of importance:

Name of operation ..... Date of .....

What test confirmed diagnosis? ..... Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:

Accident, ~~suicide, or homicide~~? Yes Date of injury 5-6 1932

Where did injury occur? St. Louis Mo.
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place. Home

Manner of injury Fall from Window

Nature of injury Fractured Skull

24. Was disease or injury in any way related to ~~occupation of deceased~~? .....

If so, specify .....

(Signed) [illegible], M. D.

(Address) [illegible]

5/6/32