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

CEC APR 1 1938

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

791

8696
Do not use this space.

1. PLACE OF DEATH

(a) County ..... Registration District No. 1008

(b) Township ..... Primary Registration District No. ..... Registered No. 2285

(c) City St. Louis Mo. (d) Street No. BARNES HOSPITAL St.
(If death occurred in Hospital or Institution, write its name instead of street and number)

(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Beulah Mae Chambers 516

(a) Residence, No. Monticello, Ill. St. N.R. Monticello Ill.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) December 2nd 1915

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
22	3	4	

OCCUPATION

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

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

10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Monticello Illinois

FATHER

13. NAME Frank Ater

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Monticello Illinois

MOTHER

15. MAIDEN NAME Margaret Shiffler

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Maroa Illinois

17. INFORMANT Margaret Ater
(ADDRESS) Monticello Ill.

18. BURIAL, CREMATION, OR REMOVAL
PLACE Monticello Ill. DATE 3-7-38 19

19. FUNERAL DIRECTOR Albert H. Hoppe
(ADDRESS) 429 No. Euclid, Ave.

20. FILED MAR 7 1938 J. H. Bredeck
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 6th 1938

22. I HEREBY CERTIFY, That I attended deceased from January 16th, 1938 to March 6th, 1938.
I last saw her alive on March 6th, 1938. Death is said to have occurred on the date stated above, at 1.05 A.M.
The principal cause of death and related causes of importance were as follows:

	Date of onset
BRAIN TUMOR	6 MO
(SPONGIOBLASTOMA MULTIFORME	

Other contributory causes of importance:

Name of operation CRANIOTOMY Date of JAN.
What test confirmed diagnosis? OPERATION Was there an autopsy? YES

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury, 19
Where did injury occur?
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
If so, specify
(Signed) H. Hoffner, M. D.
(Address) BARNES HOSPITAL

(Licensed Embalmer's Statement on Reverse Side)

53

2285

2285

STATEMENT BY LICENSED EMBALMER

I, ..., Licensed Embalmer No. 1122

hereby certify that the body recorded on the reverse side of this certificate was embalmed by.....

.....L. E.....

No.....or by....., Registered Apprentice No.....

working under my personal supervision.

Signed J. B. Sullivan

Licensed Embalmer No. 1122

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

File No. 8696
Registered No. 2285

1. PLACE OF DEATH

County St Louis
Township
City St Louis (No. Barnes Hosp St. Ward)

Registration District No. 791
Primary Registration District No. 1003

2. FULL NAME Beulah Mae Chambers

(a) Residence, No. St., Ward. Monticello, Ill
(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) M

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

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

7. AGE — YEARS 22 — MONTHS — DAYS — If LESS than 1 day, ...hrs. or ....min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

FATHER

13. NAME
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER

15. MAIDEN NAME
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL
PLACE DATE 19

19. UNDERTAKER (ADDRESS)

20. FILED MAY 3 1938 19 J. F. Bredeck Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 6, 1938

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 ....m.

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

	Date of onset
Brain tumor	6 mo.
Astrocytoma Multiforme	
Malignant	

Other contributory causes of importance:

63C

Name of operation Craniotomy Date of Jan
What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury ....19....
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
If so, specify
(Signed) A. Haffner, M. D.
(Address) Barnes Hosp

SUPPLEMENTARY

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.
REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.