JAN 17 1939

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

43230
Do not use this space.

1. PLACE OF DEATH
(a) County Henry 2
(b) Township Bogard 1
(c) City or Ulrich 1
Registration District No. 347
Primary Registration District No. J485
Registered No.
(d) Street No. 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 0 yrs. 11 mos. 20 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

42

2. PRINT FULL NAME 5/6 Charles M. Chamberlin
(a) Residence, No. Ulrich St.
(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)
Male	white	single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec-23-37

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ...min.
0	11	20	

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. —
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) Ulrich Missouri

FATHER
13. NAME Milton Chamberlin
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Houstonia Mo

MOTHER
15. MAIDEN NAME Grace E. Greene
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Trenton Mo

17. INFORMANT (ADDRESS) Milton Chamberlin Ulrich Mo

18. BURIAL, CREMATION, OR REMOVAL
PLACE Hughesville DATE Dec-15 1938

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Fred Wilkinson Clinton Mo

20. FILED 12-31 1938 Dr J R Knighton Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec-13 1938

22. I HEREBY CERTIFY, That I attended deceased from Dec 5 1938, to Dec 13 1938.
I last saw him alive on Dec 13 1938. Death is said to have occurred on the date stated above, at 7:30 Am.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Bronchial Pneumonia	
Heart Failure	

Other contributory causes of importance:

Name of operation Date of
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) Guy L Wetzel M. D.
312 (Address) Clinton, Mo.

(Licensed Embalmer's Statement on Reverse Side)

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.

1 X16805

1972

RECEIVED
District Health Officer No. 7
District File Number 1-39-10
Date Filed 1-4-39

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed Fred Wilkinson

Licensed Embalmer No. 2478

P. O. Address Clinton Ill

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

If this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

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REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS REQUIRED BY LAW.

1. PLACE OF DEATH
(a) County Henry Registration District No. 347
(b) Township Bogard Primary Registration District No. 3485 Registered No.
(c) City (d) Street No. 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 Charles M. Chamberlin
(a) Residence, No. St.
(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: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): S
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
6. DATE OF BIRTH (MONTH, DAY, AND YEAR)
7. AGE Years — Months 11 — Days 20 — If LESS than 1 day, ...hrs. or ......min.

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

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. FUNERAL DIRECTOR (ADDRESS)
20. FILED , 19 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12 - 13 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
Brochial Pneumonia
Heart failure 10 d
due to Exhaustion at time
Other contributory causes of importance:
of illness. was not Congenital N.M.D.
Name of operation Date of
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) Geo. S. Wetzel, M. D.
(Address) Clinton Mo

SUPPLEMENTARY

BOLIVAR MO

I X12421

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Do not use this space.

1. PLACE OF DEATH

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

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

(c) City ..... (d) Street No. ..... Ward.....

(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. ..... da. (f) How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... da.

2. PRINT FULL NAME .....

(a) Residence, No. ..... St. ..... (If nonresident, give city or town and State)

(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

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

3a. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

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

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

OCCUPATION

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

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) .....

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. FUNERAL DIRECTOR (ADDRESS) .....

20. FILED ....., 19..

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) ....., 19..

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

Other contributory causes of importance:

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

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) ....., M. D.

(Address) .....

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