

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.

nr. Graham

NOV - 4 1939

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

35953  
Do not use this space.

1. PLACE OF DEATH

(a) County Davess Registration District No. 251  
(b) Township Grandriver Primary Registration District No. 5350 Registered No. \_\_\_\_\_  
(c) -City Gaccatin (d) Street No. \_\_\_\_\_ (If death occurred in Hospital or Institution, write its name instead of street and number) St. \_\_\_\_\_  
(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

CHARLES CHAMBERLAIN  
(a) Residence, No. \_\_\_\_\_ St.  (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 Widowed  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Olive Chamberlain  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 28 - 1855  
7. AGE YEARS 84 MONTHS 2 DAYS 6 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retired  
9. Industry or business in which work was done, as saw mill, bank, etc. Farmer.  
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) Illinois

FATHER 13. NAME Ebenezer Chamberlain

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

MOTHER 15. MAIDEN NAME Elizabeth Boyd

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

17. INFORMANT (ADDRESS) Allen Chamberlain Gaccatin Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Bethel Cem. DATE Aug. 4 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) J. Roberson Jonesport Mo.

20. FILED Oct 10 1939 Ava (Pugh) Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug. 2 1939

22. I HEREBY CERTIFY, That I attended deceased from July 14, 1939 to Aug 2, 1939  
I last saw him alive on Aug 18, 1939 Death is said to have occurred on the date stated above, at 8:00 m.  
The principal cause of death and related causes of importance were as follows:  
Valvular Heart Disease (1937)

Other contributory causes of importance: g. d. h.

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) J. Roberson M. D.

(Address) Jonesport Mo.

RECEIVED

Health Officer No. 11)

1139-1548  
NOV 14 1939

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**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

*O. L. Robertson*

Licensed Embalmer No.

*3244*

P. O. Address

*Jamestown, Me*

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

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