

MAY 15 1940

Registration District No. 821

Primary Registration District No. 4553

Registrar's No. _____

1. PLACE OF DEATH:
(a) County Scott
(b) City or town Sikeston 2
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
North Frisco Street
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Scott
(c) City or town Sikeston
(If outside city or town limits, write "RURAL")
(d) Street No. North Frisco
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Maggie Chambers 5/6
3. (b) If veteran, name war _____
3. (c) Social Security No. none

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month April day 1st
year 1940 hour 8 minute 00 P.M.

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife Ben Chambers
6. (c) Age of husband or wife if alive D years
7. Birth date of deceased November 17 1885
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 11-13-39
_____, 19____, to 4-1-40, 19____;
that I last saw her alive on _____, 19____;
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
54 4 15 _____ hr. _____ min.

Immediate cause of death Carcinoma of the stomach
Due to _____ years
Due to _____

9. Birthplace Lyon County Kentucky
(City, town, or county) (State or foreign country)
10. Usual occupation Housewife

Other conditions Carcinoma of the liver
(Include pregnancy within 3 months of death)
Major findings: Of operations
Of autopsy _____

11. Industry or business Champion Oliver
12. Name _____
13. Birthplace Lyon County Kentucky
(City, town, or county) (State or foreign country)
14. Maiden name Malinda Cochran
15. Birthplace Lyon County Kentucky
(City, town, or county) (State or foreign country)

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant's own signature Clay Browning
(b) Address Sikeston, Missouri
17. (a) Burial (b) Date thereof April 3, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Memorial Park Cemetery
18. (a) Signature of funeral director Harold Brown
(b) Address Sikeston, Missouri
19. (a) 5-9-1940 (b) [Signature]
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
_____ (Specify type of place) (e) Means of injury _____
23. Signature Thomas C. McClellan
Address Sikeston Date signed 4-4-40

WHILE FATHER USE CONTINUING BLACK INK—MAKE 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.

RECEIVED

District Health Officer No. 2,

District File Number 540-103

Date Filed 5/14/40

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

Harvey Johnson

Licensed Embalmer No.

3704

P. O. Address

Sixtons, Mo

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.