

1. PLACE OF DEATH: Callaway  
 (a) County Callaway  
 (b) City or town Sullivan Mo. Calas  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: State Hospital No. 1  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 9-20-1930  
to 6-25-1942 (Specify whether  
 In this community years, months or days) 11-9-5

3. (a) PRINT FULL NAME Henry Chambers  
 (b) If veteran, name war DK (c) Social Security No. None

4. Sex Male 5. Color or race Blacks 6. (a) Single, widowed, married, divorced, Separated  
 (b) Name of husband or wife. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased 1917  
 (Month) (Day) (Year)

8. AGE: Years off. 60 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Mississippi 1  
 (City, town, or county) (State or foreign country)

10. Usual occupation Teamster

11. Industry or business \_\_\_\_\_

12. Name DK

13. Birthplace Mississippi 1  
 (City, town, or county) (State or foreign country)

14. Maiden name DK

15. Birthplace Mississippi 1  
 (City, town, or county) (State or foreign country)

16. (a) Informant Records

(b) Address State Hosp # 1

17. (a) Removed (b) Date thereof 6-26-42  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Columbia mo

18. (a) Signature of funeral director J. B. Roberts

(b) Address Columbia mo

19. (a) 6-26-42 (b) Joan Monackoff  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: 1 14  
 (a) State Mo (b) County 1  
 (c) City or town City of St. Louis 2  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. City Bonaterrum  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A.? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 25<sup>th</sup>  
 year 1942 hour 1 minute 35 A.M.

21. I hereby certify that I attended the deceased from May 18  
18 to June 25<sup>th</sup>, 1942  
 that I last saw him alive on June 25<sup>th</sup>, 1942  
 and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (include pregnancy within 3 months of death) 12 ft

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) None

(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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature J. B. Stokes (M. D. or other)

Address State Hospital No. 1 Date signed 6-25-42

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

14  
0  
2

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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.....

Licensed Embalmer No.....

P. O. Address.....

**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, fact should be so stated above.**