

FILED JUL 31 1943 318

Registration District No. **318**

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL," and name of township)
(c) Name of hospital or institution:
Ex Route to City Hospital 3
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 2 years (Specify whether)
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jefferson
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 1462 1/2 Union
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME LEWIS ANTHONY CHAMBERLAIN

MEDICAL CERTIFICATION

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

20. DATE OF DEATH Month 7 day 23
year 1943 hour 8 minute 30 P.M.

4. Sex male 5. Color or race W. 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Carroll Chamberlain 6. (c) Age of husband or wife if alive 65 years
7. Birth date of deceased July 1, 1874
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____
that I last saw h_____ alive on _____, 19____
and that death occurred on the date and hour stated above.

8. AGE: Years 69 Months 0 Days 22 If less than one day _____ hr. _____ min.

Immediate cause of death Coronary Occlusion
Coronary Sclerosis
Due to Chrom Endocarditis
Due to _____

9. Birthplace East St. Louis Mo.
(City, town, or county) (State or foreign country)

Other conditions (Include pregnancy within 3 months of death) 92

10. Usual occupation Dentist

Major findings:
Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

11. Industry or business _____
12. Name Avery B. Chamberlain
13. Birthplace Virginia
(City, town, or county) (State or foreign country)
14. Maiden name Jessie Mitchell
15. Birthplace Maryland
(City, town, or county) (State or foreign country)

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? _____

16. (a) Informant Caroline Chamberlain
(b) Address 1462 1/2 Union
17. (a) Burial (b) Date thereof July 27, 1943
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Zion Church
18. (a) Signature of funeral director Samuel B. Pfeiffer
(b) Address De Soto Mo.
19. (a) JUL 23 1943 (b) _____
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place)
(a) Means of injury 3
23. Signature Thomas F. Callahan (M. D. or other) _____
Address Deputy Coroner Date signed 7-23-43

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

MOTHER FATHER

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. *4104*

P. O. Address..... *Dehato Ma*

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.