

STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

Registration District No. 98

Primary Registration District No. 455-5368

Registrar's No. 94

1. PLACE OF DEATH:

(a) County Daviess  
(b) City or town Coffey  
(c) Name of hospital or institution \_\_\_\_\_  
(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 Daviess 31  
(c) City or town Coffey  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME James Alexander Chambers

3. (b) If veteran, name war L 3. (c) Social Security No. \_\_\_\_\_

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Maggie Chambers 6. (c) Age of husband or wife if alive 79 years

7. Birth date of deceased May 8 1867  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>79</u>	<u>4</u>	<u>5</u>	hr. min.

9. Birthplace Harrison County Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Salesman

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

12. Name John R. Chambers

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

14. Maiden name Elizabeth Cochran

15. Birthplace New York City N.Y.  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Gladys Eades  
(b) Address Coffey Mo

17. (a) Burial Coffey (b) Date thereof 9-16-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Miriam Cemetery

18. (a) Signature of funeral director Joe E. White  
(b) Address Bethany Mo

19. (a) 9-26-46 (b) Regina Engelbert  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 13  
year 1946 hour 7 minute 30 A.M.

21. I hereby certify that I attended the deceased from 1942  
\_\_\_\_\_ 19\_\_\_\_ to Sept. 13, \_\_\_\_\_, 1946;  
that I last saw him alive on Sept. 13, \_\_\_\_\_, 1946;  
and that death occurred on the date and hour stated above.

Immediate cause of death Acute ascending paralysis. Duration 5 yrs.

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

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations g2  
Of autopsy \_\_\_\_\_

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

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury 2

23. Signature T.S. Bueingardner (M. D. or other) Dr.  
Address Coffey Mo Date signed 9-20-46

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

MOTHER FATHER

DISTRICT HEALTH OFFICE  
Cameron, Mo.

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..... *Joe E. Wheeler*.....

Licensed Embalmer No. *3512*.....

P. O. Address *Bethany 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, fact should be so stated above.