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DEPARTMENT OF COMMERCE...
BUREAU OF THE CENSUS
FILED JAN 13 1947
Registration District No. 209

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

41331

State File No.

Primary Registration District No. 3043

Registrar's No. 415

1. PLACE OF DEATH:
(a) County Marion
(b) City or town Hannibal
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Elizabeth's Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 days
(Specify whether years, months or days)
In this community 5 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Illinois (b) County Pike
(c) City or town Pittsfield
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME Brenda Kay Chamberlain
3. (b) If veteran, name war no
3. (c) Social Security No. no

4. Sex female 5. Color or race white
6. (a) Single, widowed, married, divorced single
6. (b) Name of husband or wife.....
6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased December 22 1946
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
- - 5 hr. min.

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

10. Usual occupation Infant

11. Industry or business.....

12. Name Donald Chamberlain

13. Birthplace Pike County Illinois
(City, town, or county) (State or foreign country)

14. Maiden name Norma Goode
15. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Donald Chamberlain
(b) Address Pittsfield, Illinois

17. (a) burial (b) Date thereof Dec. 28, 46
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Wesley Cemetery

18. (a) Signature of funeral director John Butler - City Service
(b) Address Pittsfield, Illinois

19. (a) 12-31-46 (b) W. E. M. Lucke
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December Day 26
year 1946 hour 11 minute 15 A.M.
21. I hereby certify that I attended the deceased from Dec. 23
19 46 to December 26, 19 46
that I last saw her alive on December 26, 19 46
and that death occurred on the date and hour stated above.

Immediate cause of death Respiratory Paralysis
Due to Cerebral Hemorrhage

Other conditions (Include pregnancy within 3 months of death)
Major findings: None
Of operations.....
Of autopsy No autopsy

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 P.T. Dalar M.D. (M. D. or other)
Address Barry, Ill Date signed 31 Jan 46

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

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

401

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.