No. 2
-1/47
17/39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED MAY 17 1948
Registration District No. 222

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 3074

State File No. 18388
Registrar's No. 53

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

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Scott 160
(c) City or town Sikeston, Mo. 5
(If outside city or town limits, write "RURAL")
(d) Street No. 118A N. Kingshighway 2
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME GENEVA CHAMBERLIAN
3. (b) If veteran, name war —
3. (c) Social Security 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 Oct. (Month) 29 (Day) 1919 (Year)

8. AGE: Years 28 | Months 6 | Days 3 | If less than one day — hr. — min.

9. Birthplace New Madrid County Mo. (City, town, or county) (State or foreign country)
10. Usual occupation Bookeeper
11. Industry or business
FATHER
12. Name Steve Chamberlian
13. Birthplace New Madrid County, Mo. (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name JennieFrohock
15. Birthplace New Madrid County Mo. (City, town, or county) (State or foreign country)
16. (a) Informant Mother
(b) Address New Madrid, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-4-48 (Month) (Day) (Year)
(c) Place: burial or cremation Evergreen Cemetary
18. (a) Signature of funeral director Taylor Funeral Home
(b) Address Sikeston, Mo.
19. (a) 5-8-48 (Date received local registrar) (b) Mrs T F Henry 202 (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month May day 2 year 1948 hour 5 minute A. M.
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.

	Duration
Immediate cause of death: Over dose of sleeping Capsules	
Due to - - - - - -	
Due to - - - - -	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) 160
(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)
While at work? (e) Means of injury 3
23. Signature Orville Taylor Coroner (M.D. or other)
Address Sikeston Mo Date signed 5-4-48

Jefferson City Printing Co.
(Licensed Embalmer's Statement on Reverse Side)

PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED
District Health Office No. 2,
District File Number 548-612
Date Filed 5-13-48

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 James M. Scott

Licensed Embalmer No. 4350

P. O. Address East Prairie

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.

No. 2B
M—3-45
X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. June

Registration District No. 333 Primary Registration District No. 3074 Registrar's No. 53

1. PLACE OF DEATH:

(a) County: Scott

(b) City or town: Sikeston (If outside city or town limits, write "RURAL" and name of township)

(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 years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town (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: Geneva Chamberlain

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex: F

5. Color or race: W

6. (a) Single, widowed, married, divorced: S

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive

7. Birth date of deceased: Oct (Month) 24 (Day) (Year)

8. AGE: Years 28 Months 6 Days 3 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

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

14. Maiden name

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

16. (a) Informant

(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May year 1948 hour minute M.

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.

Immediate cause of death — Duration

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations

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) accident

(b) Date of occurrence May 2, 1948

(c) Where did injury occur? Sikeston (City or town) Scott (County) Mo. (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Sikeston General Hospital (Specify type of place)

While at work? No (e) Means of injury over-dose of sleeping tablets

23. Signature Orville Taylor (M. D. or other)

Address Sikeston, Mo. Date signed 5/4/48

SUPPLEMENTARY

5-18388