S. No. 300
v. 10.48

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

FILED AUG 25 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 28124
Registrar's No. 7302

BIRTH NO. 39284-51 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1000

1. PLACE OF DEATH
a. COUNTY: St. Louis
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Louis Children's Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: ~~St. Louis~~
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis 2229
d. STREET ADDRESS (If rural, give location): 1727 Lorejoy Lane

3. NAME OF DECEASED (Type or Print)
a. (First): Derries
b. (Middle): Clarence
c. (Last): Chambers III

4. DATE OF DEATH (Month) (Day) (Year): 8-15-51

5. SEX: M
6. COLOR OR RACE: N
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): U
8. DATE OF BIRTH: 6-8-51
9. AGE (In years last birthday): IF UNDER 1 YEAR Months: 2 Days: IF UNDER 24 HRS. Hours: Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): St. Louis - Mo.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13a. FATHER'S NAME: Derries C. Chambers Sr.
13b. MOTHER'S MAIDEN NAME: Naomi McCombs
14. NAME OF HUSBAND OR WIFE:
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT'S SIGNATURE OR NAME: D. Sheller
ADDRESS: 500 S. Kingshighway

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Diarrhea, acute

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?: 571.0

22. *I hereby certify that I attended the deceased from* 8-14, 1951, *to* 8-15, 1951, *that I last saw the deceased alive on* 8-15, 1951, *and that death occurred at* 12 40 a m., *from the causes and on the date stated above.*

23a. SIGNATURE: Don L. Smith M.D. (Degree or title)
23b. ADDRESS: Children's Hosp.
23c. DATE SIGNED: 8-16-51

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: 8/17/51
24c. NAME OF CEMETERY OR CREMATORY: Booker T. Washington
24d. LOCATION (City, town, or county) (State): E. St. Louis Ill

DATE REC'D BY LOCAL REG. AUG 16 1951
REGISTRAR'S SIGNATURE: J. Earl Smith M.D.
W.J.G.

25. FUNERAL DIRECTOR'S SIGNATURE: R.M.C. Green
ADDRESS: 3517 Laclede Ave

(Licensed Embalmer's Statement on Reverse Side)

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.....

.....

working under my personal supervision.

Student Embalmer No.....

Signed Melvin E. Green

Signed.....
Student Embalmer

Licensed Embalmer No. 4428

P. O. Address St. Louis, 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.