

No. 300  
10.48

FILED FEB 4 1952

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

882

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 77

3096

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

1. PLACE OF DEATH a. COUNTY <u>GREENE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>GREENE</u>	
b. CITY OR TOWN <u>Springfield</u>	c. LENGTH OF STAY (in this place) <u>6 WEEKS</u>	c. CITY OR TOWN <u>Springfield 0396</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>City Hospital</u>		d. STREET ADDRESS (If rural, give location) <u>1202 SHERMAN</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>JESSE</u> b. (Middle) <u>C.</u> c. (Last) <u>CHAMBERLAIN</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>JAN 25 1952</u>
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5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>April 23 1871</u>	9. AGE (years last birthday) <u>80</u>	IF UNDER 1 YEAR: Months <u>9</u> Days <u>2</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED R.R.</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>	11. BIRTHPLACE (State or foreign country) <u>TEXAS</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>UNKNOWN</u>	13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	14. NAME OF HUSBAND OR WIFE <u>DECEASED</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>	16. SOCIAL SECURITY NO. <u>NO</u>	17. INFORMANT'S SIGNATURE OR NAME <u>GUSSIE WEST</u>	ADDRESS <u>Los Angeles Calif.</u>
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Hypostatic pneumonia</u>		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from Jan 1949, to Jan 25 1952, that I last saw the deceased alive on Jan 24 1952, and that death occurred at 5:50A.M., from the causes and on the date stated above.

23a. SIGNATURE <u>Leman W. Brown M.D.</u> (Degree or title)	23b. ADDRESS <u>307 1/2 College Spfld. Mo</u>	23c. DATE SIGNED <u>Jan 28 1952</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>JAN. 29 1952</u>	24c. NAME OF CEMETERY OR CREMATORY <u>HAZELWOOD</u>	24d. LOCATION (City, town, or county) (State) <u>Springfield Mo.</u>
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DATE REC'D BY LOCAL REG. <u>1-28-52</u>	REGISTRAR'S SIGNATURE <u>JAMES T. AMOS</u>	468	25. FUNERAL DIRECTOR'S SIGNATURE <u>W.P. CAMPBELL</u>	ADDRESS <u>825 WASHINGTON</u>
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APR 21 1969

**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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed K. P. Campbell

Licensed Embalmer No. 1747

P. O. Address Springfield

**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.