

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33007

FILED SEP 24 1953

State File No. _____

318

1003

7897

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (in this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		g 129	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Mary's Infirmary				d. STREET ADDRESS (If rural, give location) 4606 Vernon Ave.			
3. NAME OF DECEASED (Type or Print) JOHN		a. (First)		b. (Middle)		c. (Last) CHAMBERS	
4. DATE OF DEATH 8-9-53		(Month)		(Day)		(Year)	
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Feb. 10, 1893	
9. AGE (In years last birthday) 60		IF UNDER 1 YEAR (Months) 6		IF UNDER 1 YEAR (Days) _____		IF UNDER 1 WEEK (Hours) _____ (Min.) _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Shoe Factory		11. BIRTHPLACE (State or foreign country) Maryville, Ohio		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME G.B. Chambers		13b. MOTHER'S MAIDEN NAME Kate Cooper		14. NAME OF HUSBAND OR WIFE Eurydia Chambers			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME Eurydia Chambers ADDRESS 4606 Vernon Ave.			
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypertensive Heart Disease ANTECEDENT CAUSES Morbid conditions, if any, giving DUE TO (b) None rise to the above cause, (a) stating the underlying cause last. DUE TO (c) None II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None INTERVAL BETWEEN ONSET AND DEATH _____					
19a. DATE OF OPERATION None		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE <input checked="" type="checkbox"/> (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) X		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 443X			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) X		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? X			
22. I hereby certify that I attended the deceased from 6-21 19 53 to 8-9-53 , 19____, that I last saw the deceased alive on 8-9- 19 53 , and that death occurred at 10:05 P.M. from the causes and on the date stated above.							
23a. SIGNATURE Alva Moore, M.D. (Degree or title)		23b. ADDRESS 4501a - Easton Avenue		23c. DATE SIGNED 8-12-53			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 8-13-53		24c. NAME OF CEMETERY OR CREMATORY Washington Park Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis County, Missouri	
DATE REC'D BY LOCAL REG. AUG 12 1953		REGISTRAR'S SIGNATURE J. Carl Smith, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE Ellis Funeral Home, Inc. ADDRESS 2820 Stoddard St.			
(Licensed Embalmer's Statement on Reverse Side)							

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

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 *James A. Carter* _____

Licensed Embalmer No. *44481* _____

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.