

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **1243**

BIRTH NO. **FILED FEB 11 1954** REG. DIST. NO. **149** PRIMARY REG. DIST. NO. **1002** Registrar's No. **408**

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

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission.)			
a. COUNTY <b>JACKSON</b>		b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>KANSAS CITY</b>		a. STATE <b>MISSOURI</b>		b. COUNTY <b>JACKSON</b>	
c. LENGTH OF STAY (in this place) <b>4 1/2 YEARS</b>		c. CITY OR TOWN <b>KANSAS CITY</b>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>LITTLE SISTERS OF THE POOR</b>				e. STREET ADDRESS (If rural, give location) <b>5331 HIGHLAND</b>			
3. NAME OF DECEASED				4. DATE OF DEATH			
a. (First) <b>LILLIAN</b>		b. (Middle)		c. (Last) <b>CHAMBERS</b>		(Month) (Day) (Year) <b>Jan. 22 1954</b>	
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>NEVER MARRIED D</b>		8. DATE OF BIRTH <b>Aug. 24, 1884</b>	
9. AGE (In years last birthday) <b>69</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED NURSE</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) <b>COLONA, ILLINOIS</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13a. FATHER'S NAME <b>ANDREW JACKSON CHAMBERS</b>		13b. MOTHER'S MAIDEN NAME <b>FEBE WYMAN</b>		14. NAME OF HUSBAND OR WIFE <b>NONE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Little Sisters of the Poor K. C. Mo.</b>			
18. CAUSE OF DEATH				MEDICAL CERTIFICATION			
Enter only one cause per line for (a), (b), and (c)				I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral Hemorrhage</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 hrs</b>	
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.				ANTECEDENT CAUSES			
				Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) <b>Hypertension</b>	
				DUE TO (c) <b>Arteriosclerosis</b>		DUE TO (c) <b>Arteriosclerosis</b>	
				II. OTHER SIGNIFICANT CONDITIONS		331X	
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 checked="" type="checkbox"/>		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 <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>3/19</b> , 19 <b>52</b> , to <b>1/22</b> , 19 <b>54</b> , that I last saw the deceased alive on <b>1/21</b> , 19 <b>54</b> , and that death occurred at _____ m., from the causes and on the date stated above.							
23a. SIGNATURE <b>Joseph A. Fogarty</b> (Degree or title) <b>Joseph A. Fogarty M.D.</b>				23b. ADDRESS <b>402 Northman Sq K.C. Mo</b>		23c. DATE SIGNED <b>1/25/54</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE <b>Jan. 25, 1954</b>		24c. NAME OF CEMETERY OR CREMATORY <b>FLORAL HILLS CEMETERY</b>		24d. LOCATION (City, town, or county) (State) <b>KANSAS CITY, MO.</b>	
DATE REC'D BY LOCAL REG. <b>1-26-54</b>		REGISTRAR'S SIGNATURE <b>Steraldine Smith</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>QUIRK &amp; TOBIN, 20 W. Linwood K.C. MO.</b>			

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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.....  
Signature of Student Embalmer

Signed *Jarrest D. Coldsnow*.....

Licensed Embalmer No. *471*.....

P. O. Address *P. C. M.*.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.