

health, Welfare public service
 300
 -56
 diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes. All symptoms will be listed. All

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

162b-58

1516

FILED FEB 14 1958

STATE FILE NUMBER

Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 49

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Independence</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Blue Springs</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>Indep. Hospital</u>		Length of stay in lb		d. STREET ADDRESS <u>Route # 2</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Donald Lee Chamberlain</u>			4. DATE OF DEATH <u>Jan-28-1958</u>			Month <u>Jan</u> Day <u>28</u> Year <u>1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan-27-1958</u>	9. AGE (In years last birthday) <u>1</u>	IF UNDER 1 YEAR Months <u>-</u> Days <u>1</u>	IF UNDER 24 HRS. Hours <u>-</u> Min. <u>-</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (City and state or country) <u>Independence, Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>usa</u>	
13. FATHER'S NAME <u>Donald Lee Chamberlain Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Crull</u>			
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>none</u>		17. INFORMANT <u>Donald Lee Chamberlain</u> Address <u>Blue Spring Mo</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia -</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Congenital pulmonary fibrosis.</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>7630</u>				
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		20g. COUNTY STATE	
21. I attended the deceased from <u>Birth - 1-27</u> , to <u>Jan 28 - 58</u> and last saw ^{her} him alive on <u>1-28-58</u> . Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>Chas E. Nickerson M.D.</u>				22b. ADDRESS <u>Independence, Mo</u>		22c. DATE SIGNED <u>1-29-58</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>Jan-29-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Floral Hills</u>		23d. LOCATION (City, town, or county) (State) <u>Independence, Mo</u>		
24. FUNERAL DIRECTOR <u>Kolaud P. Speaks</u>		ADDRESS <u>Indep.</u>		25. DATE RECD. BY LOCAL REG. <u>1-29-58</u>		26. REGISTRAR'S SIGNATURE <u>James P. Craig</u>	

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 *Rollie Fessel*

Licensed Embalmer No. *46*

P. O. Address *Indep.*

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.