

**FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**60-012435**

**FILED VS MAR 24 1960**

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. 2-2653 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b	c. CITY OR TOWN <b>St. Louis</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>58 Nina Pl.</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS <b>766 Euclid</b> (If outside, give location)
			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) <b>James Chambers</b>	First	Middle	Last	4. DATE OF DEATH Month <b>3</b> Day <b>2</b> Year <b>60</b>
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5. SEX <b>M</b>	6. COLOR OR RACE <b>Col.</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>6-23-95</b>	9. AGE (last birthday) <b>64</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Janitor</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (City and state or country) <b>Tenn.</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
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13a. FATHER'S NAME <b>James H. Chambers</b>	13b. MOTHER'S MAIDEN NAME <b>Unknown</b>	14. NAME OF HUSBAND OR WIFE <b>Sarah Chambers</b>
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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)	16. SOCIAL SECURITY NO.	17. INFORMANT <b>Sarah Chambers-766 N. Euclid</b>	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>hypertensive cardio vascular disease</b> <i>Hypertensive Cardio Vascular Dis.</i>	INTERVAL BETWEEN ONSET AND DEATH <b>3 1/2 yrs</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>443x</b>	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
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21. I attended the deceased from **9-24-56** to **3-20-60** and last saw him alive on **2-20-60**  
Death occurred at **3-2-60** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>James M. Wittico</b> (Degree or title) <i>James M. Wittico, M.D.</i>	22b. ADDRESS <b>916 A. W. TAYLOR</b>	22c. DATE SIGNED <b>3-5-60</b>
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23a. BURIAL, CREMATION, OR OTHER FINAL DISPOSITION (Specify) <b>Burial</b>	23b. DATE <b>3-7-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary</b>	23d. LOCATION (City, town, or county) <b>St. Louis,</b>	(State) <b>MO.</b>
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24. FUNERAL DIRECTOR <b>A.L. Beal Und. Co. - 4305 Delmar</b>	25. DATE RECD. BY LOCAL REG. <b>3-7-1960</b>	26. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b> <i>MSB</i>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

*Arthur L. Hilliard*

Licensed Embalmer No.

4221

P. O. Address

3100 Easton C

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.