

# UNITED STATES DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JUN 13 1960

60-019140

STATE FILE NUMBER

Registration District No. 133 Primary Registration District No. 2 Registrar's No. 75

1. PLACE OF DEATH a. COUNTY <u>Harrison</u>		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Harrison</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Rural Union lig</u>	Length of stay in 1b <u>71 yr.</u>	c. CITY OR TOWN <u>Rural Union lig</u>	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>at home</u>	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Ridgeway</u>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>L Avena</u> Middle <u>Katherine</u> Last <u>Chamberlin</u>	DATE OF DEATH <u>6-4-1960</u>
--	----------------------------------

5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>5-15-89</u>	9. AGE (last birthday) <u>71</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>19</u> Hours <u></u> Min. <u></u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>
-------------------------	----------------------------------	---	------------------------------------	-------------------------------------	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u></u>	11. BIRTHPLACE (City and state or country) <u>Harrison County Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>
---	--	--	--

13a. FATHER'S NAME <u>Samuel Beck</u>	13b. MOTHER'S MAIDEN NAME <u>Adella Allen</u>	14. NAME OF HUSBAND OR WIFE <u>Ottie H. Chamberlin</u>
--	--	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, <u>no</u> unknown) (If yes, give year or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>498-42-1504</u>	17. INFORMANT <u>Edgar Chamberlin</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>coronary thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>at once</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u></u> DUE TO (c) <u></u>		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Diabetes and Hypertension</u>	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
---	--

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></u>
---	---	---

20c. TIME OF INJURY Hour <u></u> a.m. <u></u> p.m. <u></u>	Month, Day, Year <u></u>
---	-----------------------------

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.) <u></u>	20f. CITY, TOWN, OR LOCATION <u></u>	COUNTY <u></u>	STATE <u></u>
--	---	---	-------------------	------------------

21. I attended the deceased from <u></u> to <u></u> and last saw her alive on <u></u> Death occurred at <u>4:00 A. M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.
---

22a. SIGNATURE (Degree or title) <u>Ernest L. Hood D.D.</u>	22b. ADDRESS <u>Bethany, Missouri</u>	22c. DATE SIGNED <u>6-6-60</u>
--	--	-----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>6-6-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Allen</u>	23d. LOCATION (City, town, or county) (State) <u>Eagleville Mo.</u>
--	----------------------------	--	--

24. FUNERAL DIRECTOR <u>M. H. Haas</u>	ADDRESS <u>Bethany Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>6-6-1960</u>	26. REGISTRAR'S SIGNATURE <u>Jella Maxey</u>
---	-------------------------------	---	---

(Licensed Embalmer's Statement on Reverse Side)

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 MB Haas

Licensed Embalmer No. 3899

P. O. Address Bethany, W

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