

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS DEC 5 1960

-60-041323

Registration District No. 59 Primary Registration District No. 4097 Registrar's No. 2020

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Cass				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Cass				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Harrisonville		Length of stay in 1b 3 yrs		c. CITY OR TOWN Harrisonville		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 403 S. Independence			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 403 S. Independence		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last JESSE GILFORD CHAMBERLAIN				4. DATE OF DEATH Month Day Year November 25, 1960				
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 2-8-1872	9. AGE (last birthday) 88		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer			10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (City and state or country) Pike County, Mo.		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME William Chamberlain			13b. MOTHER'S MAIDEN NAME Lisa Henderson			14. NAME OF HUSBAND OR WIFE Martha Lou Chamberlain		
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. none		17. INFORMANT Floyd Chamberlain, 403 S. Indep. Harrisonville, Mo				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) FRACTURE RIGHT FEMUR							INTERVAL BETWEEN ONSET AND DEATH 3 DAYS	
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)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> N. <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) FELL AT HOME					
20c. TIME OF INJURY Hour Month, Day, Year 4 (p.m.) 11-22-60	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.) HOME		20f. CITY, TOWN, OR LOCATION HARRISONVILLE		COUNTY CASS	STATE MISSOURI
21. I attended the deceased from AUG. 1957 to NOV 25 1960 and last saw him alive on 11-23-60 Death occurred 4:30 PM m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Type or title) R. Moody M.D.				22b. ADDRESS HARRISONVILLE Mo			22c. DATE SIGNED 11-25-60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 11-27-1960	23c. NAME OF CEMETERY OR CREMATORY Kilby Cemetery		23d. LOCATION (City, town, or county) (State) Curryville, Missouri			
24. FUNERAL DIRECTOR Atkinson-Dubig Harrisonville Mo				25. DATE RECD. BY LOCAL REG. NOV-27-1960		26. REGISTRAR'S SIGNATURE Mrs Kay Sebrer		

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

Robert W. Anderson

Licensed Embalmer No. 4902

P. O. Address Harmon

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