

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

**=60-044966**

**FILED VS. DEC 13 1960**

**378**

Primary Registration District No. **452**

Registrar's No. **53**

STATE FILE NUMBER

INDEXED

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Wright</u>			<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Wright</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Mountain Grove</u>		Length of stay in 1b <u>20 yrs.</u>	c. CITY OR TOWN <u>Mtn. Grove,</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location), HOSPITAL OR INSTITUTION <u>215 E/ 1<sup>st</sup> Street</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>215 E/ 2<sup>nd</sup> Street</u>		
<b>3. NAME OF DECEASED</b> (Type or print) First <u>James</u> Middle <u>Leonard</u> Last <u>Chambers</u>			<b>4. DATE OF DEATH</b> Month <u>November</u> Day <u>27</u> Year <u>1960</u>			
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. Married</b> <input checked="" type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>3-10-1876</u>	<b>9. AGE (last birthday)</b> <u>84</u>	<b>IF UNDER 1 YEAR</b> Months <u>    </u> Days <u>    </u> Hours <u>    </u> Min. <u>    </u> <b>IF UNDER 24 HR</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Saw Mill Worker</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Fired boiler</u>	<b>11. BIRTHPLACE</b> (City and state or country) <u>Lafayette County, Mo.</u>		<b>12. CITIZEN OF WHAT COUNTRY</b> <u>USA</u>	
<b>13a. FATHER'S NAME</b> <u>Edmund J. Chambers</u>		<b>13b. MOTHER'S MAIDEN NAME</b> <u>Cerelda Bates</u>		<b>14. NAME OF HUSBAND OR WIFE</b> <u>Martha (Powell) Chambers</u>		
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown)   (If yes, give war or dates of service) <u>NO</u>		<b>16. SOCIAL SECURITY NO.</b>	<b>17. INFORMANT</b> <u>Martha Jane Chambers</u> Address <u>Mtn. Grove, Mo.</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Atherosclerosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arterio Sclerosis, Hypertension</u> DUE TO (c) <u>Carcinoma Tongue</u>					INTERVAL BETWEEN ONSET AND DEATH <u>Not known</u> <u>Not known</u> <u>Not known</u>	
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"/> No <input type="checkbox"/> Unknown	
<b>19. WAS AUTOPSY PERFORMED?</b> Yes <input type="checkbox"/> NO <input type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)				
<b>20c. TIME OF INJURY</b> Hour <u>    </u> Month, Day, Year <u>    </u> a.m. p.m.						
<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>20f. CITY, TOWN, OR LOCATION</b>		<b>COUNTY</b>	<b>STATE</b>	
<b>21. I attended the deceased from</b> <u>March 1960</u> to <u>Nov. 27, 1960</u> and last saw <u>him</u> live on <u>May 24, 1960</u> Death occurred at <u>7:30 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.						
<b>22a. SIGNATURE</b> (Degree or title) <u>[Signature]</u>			<b>22b. ADDRESS</b> <u>[Address]</u>		<b>22c. DATE SIGNED</b> <u>11-30-60</u>	
<b>23b. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>	<b>23b. DATE</b> <u>12-1-1960</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Hill Crest Cemetery</u>		<b>23d. LOCATION</b> (City, town, or county) (State) <u>Mtn. Grove, Missouri</u>		
<b>24. FUNERAL DIRECTOR</b> <u>Ewell C. Craig</u> ADDRESS <u>Mtn. Grove, Missouri</u>			<b>25. DATE RECD. BY LOCAL REG.</b> <u>12-9-1960</u>	<b>26. REGISTRAR'S SIGNATURE</b> <u>[Signature]</u>		

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

*Edward C. King*

Licensed Embalmer No.

*4764*

P. O. Address

*Mt. Hope*

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