

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-004834
STATE FILE NUMBER

DEPARTMENT OF PUBLIC HEALTH AND WELFARE **71**

Registration District No. _____ Primary Registration District No. **3013** Registrar's No. **17**

AMENDED **FILED VS FEB 27 1961**

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 DATE AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF

| | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH a. COUNTY CLAY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Nebraska b. COUNTY Unkansas | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Excelsior Springs | | Length of stay in 1b 4 weeks | c. CITY OR TOWN Mason City |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Spa-View Nursing Home | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) Marie Elizabeth Chamberlin | | | 4. DATE OF DEATH Month February Day 10 Year 1961 |
| 5. SEX Female | 6. COLOR OR RACE White | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 10-13-1896 |
| 9. AGE (last birthday) 65 | | IF UNDER 1 YEAR Months _____ Days _____ | IF UNDER 24 HR Hours _____ Min. _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife-farm | | 10b. KIND OF BUSINESS OR INDUSTRY Farming | 11. BIRTHPLACE (City and state or country) Missouri |
| 12. CITIZEN OF WHAT COUNTRY U.S.A. | | 13a. FATHER'S NAME Ben Funston | |
| 13b. MOTHER'S MAIDEN NAME Unknown | | 14. NAME OF HUSBAND OR WIFE D.E. Chamberlin | |
| 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. Unknown | 17. INFORMANT J.T. Gillie, D.O. Excelsior Springs, 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) Probable peritonitis | | | INTERVAL BETWEEN ONSET AND DEATH 4 hrs. |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Intestinal perforation DUE TO (c) _____ | | | 12 hours |
| 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 checked="" 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.) | |
| 20c. TIME OF INJURY Hour _____ Month, Day, Year _____ p.m. | | | |
| 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 |
| 21. I attended the deceased from 2-9-61 , to 2-10-61 and last saw her ^{her} alive alive on 10 Feb 61 Death occurred at 3:45 A.M. on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE James T. Gillie, D.O. (Degree or title) | | 22b. ADDRESS 210 E. Broadway Excelsior Springs, Mo. | 22c. DATE SIGNED 11 Feb 61 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 23b. DATE 2-11-1961 | 23c. NAME OF CEMETERY OR CREMATORY Mason City | 23d. LOCATION (City, town, or county) (State) Mason City, Nebraska |
| 24. FUNERAL DIRECTOR Richard Funeral Home, Inc. ADDRESS Excelsior Springs, Missouri | | 25. DATE RECD. BY LOCAL REG. 2/10/61 | 26. REGISTRAR'S SIGNATURE Barbara Hutchings |

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 Louise K. Jarm

Licensed Embalmer No. 4589

P. O. Address Evolution Springs

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.