

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-022572

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 128 Primary Registration District No. 200 Registrar's No. 1022

<b>FILED JUL 9 1962</b>	
1. PLACE OF DEATH	
a. COUNTY <i>Greene</i>	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Springfield</i>	a. STATE <i>Missouri</i> b. COUNTY <i>Greene</i>
Length of stay in lb <i>2 years +</i>	c. CITY OR TOWN <i>Springfield</i>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>St. Johns Hospital</i>	d. STREET ADDRESS (If outside, give location) <i>1889 North Missouri</i>
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)	
First <i>Randy</i>	Middle <i>Lynn</i>
Last <i>Chambers</i>	4. DATE OF DEATH Month <i>June</i> Day <i>30</i> Year <i>1962</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>
7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <i>8/2/1959</i>
9. AGE (last birthday) <i>2</i>	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) <i>child</i>	10b. KIND OF BUSINESS OR INDUSTRY -----
11. BIRTHPLACE (City and state or country) <i>Aurora, Mo. Hospital</i>	12. CITIZEN OF WHAT COUNTRY <i>USA</i>
13a. FATHER'S NAME <i>Linkford Chambers</i>	13b. MOTHER'S MAIDEN NAME <i>Golda King</i>
14. NAME OF HUSBAND OR WIFE <i>none</i>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>
16. SOCIAL SECURITY NO. <i>none</i>	17. INFORMANT <i>Mr. Linkford Chambers, Springfield, Mo.</i>
Address <i>1889 N. Missouri</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:	
IMMEDIATE CAUSE (a)	INTERVAL BETWEEN ONSET AND DEATH
<i>Congestive Heart Failure</i>	<i>1 month</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	<i>4 months</i>
DUE TO (b) <i>Subendocardial Fibroelastosis</i>	
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"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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 a.m. p.m. Month, Day, Year	
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 <i>April 1962</i> and last saw her alive on <i>June 30, 1962</i>	
Death occurred at <i>6:30</i> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) <i>Raymond A. Christy, Jr. M.D.</i>	22b. ADDRESS <i>Springfield, Missouri</i>
22c. DATE SIGNED <i>7/3/62</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>July 3, 1962</i>
23c. NAME OF CEMETERY OR CREMATORY <i>Wrights Chapel Cemetery</i>	
23d. LOCATION (City, town, or county) (State) <i>Stone Co., Missouri</i>	
24. FUNERAL DIRECTOR <i>J. Alan Harris,</i>	25. DATE RECD. BY LOCAL REG. <i>7-6-62</i>
ADDRESS <i>Clever, Mo.</i>	26. REGISTRAR'S SIGNATURE <i>Effie S. Breeeton</i>

VS 300 Rev. 4/59	DATE AMENDED	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	INSTEAD OF	DOCUMENT	MEDICAL CERTIFICATION	BY AFFIDAVIT OF	ITEM NO.	SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

Percent removed 7-2-62

**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 J. Alan Harris

Licensed Embalmer No. 4390

P. O. Address Cleves, Mo.

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.