

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-032349

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **8049** STATE FILE NUMBER

DO NOT WRITE ON THIS STUB      AMENDED

VS 300  
Rev. 4/59

- 1
- 2 *215*
- 3
- 4 *0*
- 5 *2*
- 6
- 7 *1*
- 8 *2*
- 9
- 10
- 11
- 12 *75-0*
- 13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

<b>FILED AUG 31 1962</b>	
1. PLACE OF DEATH	
a. COUNTY	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis, Mo.</b>	a. STATE <b>Mo.</b> b. COUNTY
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Louis City Hosp. #1.</b>	c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. STREET ADDRESS <b>4005 Schiller Pl.</b>	d. STREET ADDRESS (If outside, give location)      Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print)	
First <b>Walter</b> Middle      Last <b>Chambers</b>	4. DATE OF DEATH <b>August 18, 18<sup>76</sup> 1962</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>
7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>7/9/97</b>
9. AGE (last birthday) <b>65</b>	IF UNDER 1 YEAR      IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>
11. BIRTHPLACE (City and state or country) <b>Fulton, Kentucky</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
13a. FATHER'S NAME <b>Jesse Chambers</b>	13b. MOTHER'S MAIDEN NAME <b>Lucretia Graham</b>
14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>Unknown</b>
17. INFORMANT <b>Katie Rogers</b>	Address <b>4005 Schiller Pl.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
PART I. DEATH WAS CAUSED BY:	
IMMEDIATE CAUSE (a) <b>Pneumonia</b>	
DUE TO (b) _____	
DUE TO (c) _____ <b>493x</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Cerebral vascular thrombosis</b>	
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.)	
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 <b>8/16/62</b> to <b>8/18/62</b> and last saw her/him alive on <b>8/18/62</b>	
Death occurred at <b>7:35 P M</b> m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <i>Edward F. Moroney, M.D.</i> (Degree or title)	22b. ADDRESS <b>1515 Lafayette Ave.</b>
22c. DATE SIGNED <b>8/18/62</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>8/20/62</b>
23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State) <b>Clinton, Kentucky</b>
24. FUNERAL DIRECTOR <b>McLAUGHLIN'S, 2301 Lafayette</b> ADDRESS	25. DATE RECD. BY LOCAL REG. <b>AUG 20 1962</b>
26. REGISTRAR'S SIGNATURE <i>Loal Smith, M.D.</i>	

USE BLACK INK OR TYPEWRITER RIBBON

**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 *James R. Chapman*  
Licensed Embalmer No. 27550  
P. O. Address St. Louis, 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.