

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-017477

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **4900** STATE FILE NUMBER

VS 300 Rev. 4/59

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2 *206*
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4 *3*
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

SHOULD READ

ITEM NO.

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

FILED MAY 9 1963

1. PLACE OF DEATH
 a. COUNTY **Mo.**
 b. CITY (If outside corporate limits, give TOWNSHIP only) **St. Louis** Length of stay in 1b
 c. CITY OR TOWN **St. Louis** Inside Limits Yes No
 d. STREET ADDRESS (If outside, give location) **4726 Cupples** Reside on Farm Yes No

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
 a. STATE **Mo.** b. COUNTY

3. NAME OF DECEASED (Type or print) First Middle Last **Ava Muriel Chambers**
 4. DATE OF DEATH Month Day Year **5-3-63**

5. SEX **F** 6. COLOR OR RACE **Negro** 7. Married Never Married Widowed Divorced
 8. DATE OF BIRTH **9-12-13** 9. AGE (last birthday) **49** 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) **Clerk** 10b. KIND OF BUSINESS OR INDUSTRY **Army-Civilian** 11. BIRTHPLACE (City and state or country) **Chase City, Va.** 12. CITIZEN OF WHAT COUNTRY **U.S.A.**

13a. FATHER'S NAME **Thomas Wilson** 13b. MOTHER'S MAIDEN NAME **Ada White** 14. NAME OF HUSBAND OR WIFE **John Chambers**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates) **No** 16. SOCIAL SECURITY NO. **[REDACTED]** 17. INFORMANT Address **267 John Chambers**

18. CAUSE OF DEATH (Enter only one cause)
 PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) **CEREBRAL ANOXIA,**
 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) **DUE TO STATUS ASTHMATICUS.**
 DUE TO (c) **241X**
 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. Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES NO 20a. ACCIDENT SUICIDE HOMICIDE 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 NOT WHILE AT WORK 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 **1956** to **5/3/63** and last saw her/him alive on **5/1/63**
 Death occurred at **10:15 P** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE **[Signature]** (Typed name) **M.D.** 22b. ADDRESS **3915 Watson Rd** 22c. DATE SIGNED **5/4/63**

23a. BURIAL, CREMATION, REMOVAL (Specify) **BURIAL** 23b. DATE **5-9-63** 23c. NAME OF CEMETERY OR CREMATORY **Newark, N.J. 581 High St.** 23d. LOCATION (City, town, or county) (State)

24. FUNERAL DIRECTOR **Bruce Funeral Home 4469 Washington** ADDRESS 25. DATE RECD. BY LOCAL REG. **MAY 6 1963** 26. REGISTRAR'S SIGNATURE **[Signature] M.D.**

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 Frederick P. Stark

Licensed Embalmer No. 4599

P. O. Address St. Louis

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.