

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

17584

1. PLACE OF DEATH

County Dunklin
Township Cape
City Hornersville (No.)

Registration District No. 287
Primary Registration District No. 4171

File No.
Registered No. 21
St. Ward

2. FULL NAME

Carlene Chambers

(a) Residence. No. St. Ward.
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Infant

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF X

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov. 14, 1929

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
1 5 18

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. X
(b) General nature of industry, business, or establishment in which employed (or employer). X
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Hornersville
(STATE OR COUNTRY) Missouri

10. NAME OF FATHER Will Chambers

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Tennessee
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Laura Pettijohn

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Arkansas
(STATE OR COUNTRY)

14. INFORMANT Will Chambers
(Address) Hornersville, Mo.

15. FILED 1-3-31 E. G. Cape
19 31 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 2, 1931

17. I HEREBY CERTIFY, That I attended deceased from April 30, 1931, to May 2, 1931, that I last saw him alive on May 2, 1931, and that death occurred, on the date stated above, at 2:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Bronchial Pneumonia

1092 (duration) yrs. mos. 4 ds.

CONTRIBUTORY (SECONDARY)

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH yes

DID AN OPERATION PRECEDE DEATH? no DATE OF

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) Van H. Bonds, M. D.

, 19 (Address) Hornersville Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

Horners Cemetery May 3 1931

20. UNDERTAKER ADDRESS

McDauie Fun. Co Berath, Mo.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

JUN 25 1931

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Stunklin Registration District No. 287 File No. _____
 Township _____ Primary Registration District No. 4171 Registered No. 21
 City Homersville St. _____ Ward _____

2. FULL NAME

Carlene Chambers

(a) Residence. No. _____ St. _____ Ward _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED S
(For the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) _____
 (STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
 (STATE OR COUNTRY)

14.

INFORMANT _____
 (Address)

15.

FILED _____, 19____ REGISTRAR _____

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 2, 1931

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw him _____, and that death occurred, on the date stated above, at _____.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Streptho pneumonia
Neither measles or whooping cough
 CONTRIBUTORY (SECONDARY) _____
 (Address) _____

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) _____, M. D.

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW
 INFORMATION SHOULD BE CAREFULLY SUPPLIED. AGE SHOULD BE STATED EXACTLY. PHYSICIANS SHOULD STATE IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED. EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT.

SUPPLEMENTARY

5-19584