

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

Deed of  
 Received DEC 12 1935

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

Do not use this space.

1. PLACE OF DEATH

County.....  
 Township.....  
 City.....

Registration District No. **791**  
**1008**  
 Primary Registration District No. **3119** *Dickson*

File No. **38021**  
 Registered No. **10033**  
 St. .... Ward)

2. FULL NAME

(a) Residence, No. **3119 Dickson St.** **18** Ward.  
 (Usual place of abode)  
 Length of residence in city or town where death occurred yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

*Mrs. Mary Chambers - Chambers*

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Married to William Chambers*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *12-21-1903*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, ..... hrs. or ..... min.  
*32 1903 11 6*

8. Trade, profession, or particular kind of work done, as splaner sawyer, bookkeeper, etc. *Housewife*

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)..... 11. Total time (years) spent in this occupation.....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Tenn.*

13. NAME *William Chambers*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Tennessee*

15. MAIDEN NAME *Mary Bagley*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Mississippi*

17. INFORMANT *William Chambers*

(ADDRESS) *3119 Dickson*

18. BURIAL, CREMATION, OR REMOVAL *Abrahamson Park* DATE *12-24* 19*35*

19. UNDERTAKER *Boyd Board*

(ADDRESS) *3706 Grand*

20. FILED *NOV 29 1935* *J. P. Bredeck* Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Nov. 27* 19*35*

I HEREBY CERTIFY That I attended deceased from *Nov. 24* 19*35*, to *Nov. 27* 19*35*. I last saw her alive on *Nov. 27* 19*35*. Death is said to have occurred on the date stated above, at *3:00 p.m.*

The principal cause of death and related causes of importance were as follows:

*Lobar Pneumonia* Date of onset *Nov. 23*

Other contributory causes of importance: *La Grippe non-specific*

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide?..... Date of injury....., 19.....

Where did injury occur?..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased? *No.*

If so, specify.....

(Signed) *J. P. Flower* M. D.

(Address) *1711 N. 10th St.*

