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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

JAN 10 1947

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 4804

Registration District No. 399 Primary Registration District No. 1002 Registrar's No.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City Mo. (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: General Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether) 4 days

In this community (years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson

(c) City or town Kansas City (If outside city or town limits, write "RURAL")

(d) Street No. 4010 Oline St (If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME VIOLA CHAMBERLAIN

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Charles W. Chamberlain

6. (c) Age of husband or wife if alive 29 years

7. Birth date of deceased July 27 1913 (Month) (Day) (Year)

8. AGE: Years 27 Months 4 Days 19 If less than one day hr. min.

9. Birthplace Gravois Mill Mo. (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business 0

FATHER
12. Name Nathan Allen
13. Birthplace Gravois Mill Mo. (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Lovella Stearens
15. Birthplace Gravois Mill Mo. (City, town, or county) (State or foreign country)

16. (a) Informant Elizabeth Allen

(b) Address 4010 Oline St K.C. Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-19-40 (Month) (Day) (Year)

(c) Place: burial or cremation Versailles Mo.

18. (a) Signature of funeral director Roy E. Snow

(b) Address 2315 Lisswood 361

19. (a) 12-18-40 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month day 12-16-40

year hour minute M.

21. I hereby certify that I attended the deceased from 11 50 a, 19 to , 19 ; that I last saw her alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death

Due to Fracture of the Skull

Due to Auto traumatism

Other conditions (Include pregnancy within 3 months of death) 210 m

Major findings: Of operations 22

Of autopsy Yes

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Accident

(b) Date of occurrence 12-14-40

(c) Where did injury occur? K.C. (City or town) (County) Mo (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Passenger in auto that collided (Specify type of place) E

While at work? (e) Means of injury

23. Signature [illegible] (M. D. or other)

Address K.C. Mo. Date signed

(Licensed Embalmer's Statement on Reverse Side)

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed Roy E. Snow

Licensed Embalmer No. 2560

P. O. Address 2315 Linwo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.