

No. 2  
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-17-39  
X32272

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 25777

FILED AUG 5 1943

Registration District No. 277

Primary Registration District No. 5913

Registrar's No. 31

1. PLACE OF DEATH:

(a) County PIKE

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

(c) Name of hospital or institution: 1  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether)

In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO

(b) County Pike

(c) City or town Curryville, Mo. Rural  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_  
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME FLAVIUS JOSEPHUS CHAMBERLAIN

3. (b) If veteran, name war NO.

3. (c) Social Security No. NO.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 30  
year 1943 hour 8 minute 45 a. M.

21. I hereby certify that I attended the deceased from Jan  
1940 to June 30, 1943  
that I last saw him alive on June 29, 1943  
and that death occurred on the date and hour stated above.

4. Sex MALE

5. Color or race WHITE

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

6. (b) Name of husband or wife LENA E. CHAMBERLAIN

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

7. Birth date of deceased SEPTEMBER 24 1861  
(Month) (Day) (Year)

Immediate cause of death Cardiac Emphysema 5 days

Due to Arteriosclerosis 3 yrs.

Due to \_\_\_\_\_

8. AGE:

Years	Months	Days	If less than one day
<u>81</u>	<u>9</u>	<u>6</u>	hr. _____ min. _____

9. Birthplace CURRYVILLE Mo. 0  
(City, town, or county) (State or foreign country)

10. Usual occupation FARMER.

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name JOHN M. B. CHAMBERLAIN

13. Birthplace UNKNOWN KENTUCKY  
(City, town, or county) (State or foreign country)

14. Maiden name RACHEL A. BRANSTETTER.

15. Birthplace CURRYVILLE Mo. 0  
(City, town, or county) (State or foreign country)

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant Eula Barrett

(b) Address Curryville, Mo.

17. (a) BURIAL (Burial, cremation, or removal)

(b) Date thereof July 2, 1943  
(Month) (Day) (Year)

(c) Place: burial or cremation NEW HARMONY CEMETERY

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

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

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)

(e) Means of injury \_\_\_\_\_

23. Signature T.M. Mathers, D.D. (M. D. or other)

Address Brewster Green Mo Date signed 4/30/43

18. (a) Signature of funeral director W. D. Water

(b) Address Vanhook Mo.

19. (a) 6/30/43 (Date received local registrar)

(b) Max Frank Gordon (Registrar's signature)

114 X (Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

District Health Officer No. 10

District File Number 8-43-1227

Date Filed AUG 4 1943

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 A. S. Waters

Licensed Embalmer No. 4295

P. O. Address Vandalia 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 this body is not embalmed, fact should be so stated above.

Registration District No. 277

Primary Registration District No. 5913

1. PLACE OF DEATH:

(a) County Platte  
(b) City or town Barryville Rural  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution. (Specify whether  
In this community. (Specify whether  
years, months or days)

3. (a) PRINT FULL NAME Flavious J. Chambelai

3. (b) If veteran, name war  
3. (c) Social Security No.

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife  
6. (c) Age of husband or wife if alive

7. Birth date of deceased Sept - 24 1925  
(Month) (Day) (Year)

8. AGE: Years 81 Months 9 Days 28 (Unless than one day min.)

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

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name (City, town, or county) (State or foreign country)

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County  
(c) City or town (If outside city or town limits, write "RURAL")  
(d) Street No. (If rural, give location)  
(e) Citizen of foreign country? (Yes or No)  
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1943 year 1943 hour 10 minute 00 M.

21. I hereby certify that I attended the deceased from 1943 to 1943,  
that I last saw him alive on 1943,  
and that death occurred on the date and hour stated above.  
Immediate cause of death

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

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

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

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY

S-25777