

FILED JAN 20 1945

Registration District No. 38

Primary Registration District No. 3006

Registrar's No. 314

1. PLACE OF DEATH:

(a) County Boone  
(b) City or town Centralia  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Boone County Hospital  
(If not in hospital or institution, write street number of location)  
(d) Length of stay: In hospital or institution 2 weeks  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

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

3. (a) PRINT FULL NAME DONOVAN DAON CHAMBERLAIN

(b) If veteran, name war NO  
(c) Social Security 488-01-8581

4. Sex M 5. Color or race W  
6. (a) Single, widowed, married, divorced Married  
(b) Name of husband or wife Nora Mc Lee Chamberlain  
(c) Age of husband or wife if alive 35 years  
7. Birth date of deceased Nov 26 1900  
(Month) (Day) (Year)

8. AGE: Years 44 Months 1 Days 1 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Railway Telegrapher

11. Industry or business  
12. Name S. S. Chamberlain  
13. Birthplace South West Ind.  
(City, town, or county) (State or foreign country)  
14. Maiden name Esther Garrison  
15. Birthplace Marshall Ind.  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. D. N. Chamberlain  
(b) Address Centralia Mo.

17. (a) Buried (b) Date thereof 12/29-1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Centralia Mo

18. (a) Signature of funeral director M. D. Barker  
(b) Address Centralia Mo 6313

19. (a) 12/29-1944 (b) Edna H. Barber  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 27  
year 1944 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from Dec 14 1944 to Dec 27 1944  
that I last saw him alive on Dec 27 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death effusion of pleurae with  
effusion of pleurae with  
effusion of pleurae with  
Due to pernicious anemia Duration 2 wks  
Due to (Tuberculosis?) 1 day

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 13  
Of autopsy \_\_\_\_\_  
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) \_\_\_\_\_  
(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 E. D. Barker (M. D. or other) M.D.  
Address Centralia Mo Date signed 12/29/45

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

22  
26/45

MAR 2 1945

RECEIVED  
District Health Officer No. 97  
District File Number.....  
Date Filed 1-19-45

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 M. J. McDonald

Licensed Embalmer No. 4313

P. O. Address Centralia 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.