

FILED MAR 3 1945
318

1003

Registration District No.

Primary Registration District No.

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

1. PLACE OF DEATH:
(a) County
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Lukes Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **25 days**
(Specify whether years, months or days)

3. (a) PRINT FULL NAME **Grace M. Chambers**
3. (b) If veteran, name war **None** **3. (c) Social Security No.** **None**

4. Sex **Female** **5. Color or race** **White** **6. (a) Single, widowed, married, divorced** **Married**
6. (b) Name of husband or wife **Robert T. Chambers** **6. (c) Age of husband or wife if alive** **48** years
7. Birth date of deceased **March 13, 1904**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
40 **11** **0** hr. min.

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

10. Usual occupation **At home**

11. Industry or business

12. Name **Owen A. Hill**
13. Birthplace **Uniontown** **Ky.**
(City, town, or county) (State or foreign country)
14. Maiden name **Bertie W. Bierman**
15. Birthplace **St. Louis** **Mo.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Robert T. Chambers**
(b) Address **Box 793 R.R. #4. Baden Station**

17. (a) Burial **(b) Date thereof** **2/17/45**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Mt. Lebanon Cemetery**

18. (a) Signature of funeral director **Math Hermann & Son**
(b) Address **2161 East Fair Ave**

19. (a) FEB 16 1945 **(b) [Signature]**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **St. Louis**
(c) City or town
(If outside city or town limits, write "RURAL")
(d) Street No. **R.R. #4 Box 793**
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb.** day **13th**
year **1945** hour **9:15 PM** minute M.

21. I hereby certify that I attended the deceased from
March 9 19**45** to **Feb. 13** 19**45**
that I last saw **her** alive on **Feb. 13, 1945**,
and that death occurred on the date and hour stated above.

Immediate cause of death
Cardiac Decompensation **4 weeks**

Due to **Mitral Stenosis & Insufficiency and Aortic Stenosis** **20 years**
Due to **Rheumatic Heart Disease**

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.

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 **David M. Skilling, Jr.** **M.D.**
4500 Olive Street **Date signed** **3/15/45**

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 Welford G Burnley
Licensed Embalmer No. 4202
P. O. Address St. Louis, 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.