

FILED JAN 25 1946
318

State File No.

Registration District No.

Primary Registration District No.

1002

Registrar's No.

491

1. PLACE OF DEATH:

(a) County.....
(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Christian Hospital
(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)

3. (a) PRINT FULL NAME Mary Ann Chamberlain

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

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced single

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

7. Birth date of deceased. December 26th 1945
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
- - 19
- - 21 hr. min.

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER { 12. Name Robert Chamberlain
13. Birthplace Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Celeste Hanley
15. Birthplace Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. Robert Chamberlain-father
(b) Address 6917 Claremore, Normandy, Mo
17. (a) burial (b) Date thereof 1-16-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Int. Calvary Cemetery

18. (a) Signature of funeral director Sullivan Undertakers
(b) Address 2849 North Euclid Avenue,

19. (a) JAN 16 1946 (b) J. F. Buresch
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town Normandys
(If outside city or town limits, write "RURAL")
(d) Street No. 6917 Claremore,
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No) /
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 15th
year 1946 hour 8 minute 20 P.M.

21. I hereby certify that I attended the deceased from see 28 1946 to Jan 15 1946
that I last saw her alive on Jan 15 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Intracranial injury, wife

Due to Birth

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 Victor E. Hrdlicka (M. D. or other)
Address 508 N. Grand Date signed 1/15/46

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

2384

Dr. Mc Elvain
GO. 2500 DE. 0300
7039 Washington - 4356 Warne

508 N. Grand
Mr. H. H. Lichten 10 ³⁰/_{Am.}
off. - Je 5 464
Pa. 7038
Met Body

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.....

Licensed Embalmer No.....

P. O. Address.....

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.