

DEPARTMENT OF COMMERCE  
 BUREAU OF THE CENSUS  
**FILED MAR 14 1946**  
 STATE BOARD OF HEALTH OF MISSOURI  
**STANDARD CERTIFICATE OF DEATH**

State File No. **5972**  
 Registrar's No. **61**

Registration District No. **146**  
 Primary Registration District No. **3026**

**1. PLACE OF DEATH:**  
**Jackson**  
 (a) County **Jackson**  
 (b) City or town **Independence**  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
**Independence Sanitarium**  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution **5 days**  
(Specify whether years, months or days)  
 In this community **16 years**  
(Specify whether years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**  
**Missouri Jackson 48**  
 (a) State **Missouri** (b) County **Jackson**  
 (c) City or town **Independence 4**  
(If outside city or town limits, write "RURAL")  
 (d) Street No. **411 So. Osage 4**  
(If rural, give location)  
 (e) Citizen of foreign country? **no**  
(Yes or No)  
 If yes, name country **11**

**3. (a) PRINT FULL NAME:**  
**WILBER CHAMBERS**  
**Spanish American**  
 3. (b) If veteran, name war  
 3. (c) Social Security No. **499-10-1776**

**MEDICAL CERTIFICATION**  
**Feb. 15**  
**20. DATE OF DEATH:** Month **Feb.** day **15**  
 year **1946** hour **2** minute **30** A. M.

4. Sex **Male**  
 5. Color or race **White**  
 6. (a) Single, widowed, married, divorced **married**  
 6. (b) Name of husband or wife **Mary Ann Chambers**  
 6. (c) Age of husband or wife if alive **65** years  
 7. Birth date of deceased **October 19 1875**  
(Month) (Day) (Year)

**21. I hereby certify that I attended the deceased from**  
**2/11 1946** to **2/15 1946**  
 that I last saw him alive on **2/14 1946**  
 and that death occurred on the date and hour stated above.

**8. AGE:**  
 Years **70** Months **3** Days **24**  
 If less than one day  
 hr. min.

Immediate cause of death:  
**Subarachnoid hemorrhage (spontaneous)**  
 Due to **arteriosclerotic + hypertensive cardiovascular disease**  
 Due to **none**

**9. Birthplace:**  
**Cold Water Michigan**  
(City, town, or county) (State or foreign country)

Other conditions (include pregnancy within 3 months of death)  
**none**

**10. Usual occupation:**  
**Pumper**

Major findings:  
 Of operations **none**  
 Of autopsy **as above**

**11. Industry or business:**  
**Indep. Waterworks Co.**

**12. Name:**  
**Edwin Chambers**

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

**14. Maiden name:**  
**Laura Alexander Ohio**  
(City, town, or county) (State or foreign country)

**15. Birthplace:**  
**Unknown Ohio**  
(City, town, or county) (State or foreign country)

**16. (a) Informant:**  
**Mary Ann Chambers**  
 (b) Address **411 So. Osage**

**17. (a) Burial** (b) Date thereof **2-18-1946**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation **Mound Grove**

**18. (a) Signature of funeral director:**  
**Independence Missouri**  
 (b) Address  
 19. (a) **2-15-46** (b) **James W. Ross**  
(Date received local registrar) (Registrar's signature)

**PHYSICIAN**  
 Underline the cause to which death should be charged statistically.  
**none**

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

While at work? (Specify type of place) (c) Means of injury  
**23. Signature: James E. Link, M.D.**  
 Address: **129 W. Lexington, Independence, Mo.** Date signed **2/15/46**

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

4961

MAR 22 1946

---

---

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..... *R. D. Lish* .....

Licensed Embalmer No..... *4123* .....

P. O. Address..... *Indy, Ind.* .....

**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.