

FILED MAY 13 1946

Registration District No. **306**

Primary Registration District No. **6208**

Registrar's No. **33**

1. PLACE OF DEATH:

(a) County Texas County.
(b) City or town Rural, Near Yukon Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Osark Township
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 79 years.
years, months or days)

3. (a) PRINT FULL NAME Calvin Sidney Chambers.

3. (b) If veteran, name war 000000-- 3. (c) Social Security No. -----

4. Sex Male, M 5. Color or race W. 6. (a) Single, widowed, married, divorced Divorced
6. (b) Name of husband or wife Martha Ann. 6. (c) Age of husband or wife if alive 70 years
7. Birth date of deceased December 2d, 1866,
(Month) (Day) (Year)

8. AGE: Years 79 Months 3 Days 12 If less than one day _____ hr. _____ min.

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

10. Usual occupation Farming.

11. Industry or business Farming.

12. Name Jasper Chambers.

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

14. Maiden name Unknown.

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

16. (a) Informant Mrs. Nora Dixon,

(b) Address Yukon Mo.

17. (a) Burial (b) Date thereof Mch. 17th '46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Osark Cemetery

18. (a) Signature of funeral director Gaylord W. ...

(b) Address Houston Mo.

19. (a) H-15-46 (b) myrtle craig
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Yukon Mo. (b) County Texas
(c) City or town Rural, near Yukon Mo.
(If outside city or town limits, write "RURAL")
(d) Osark Township
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 14th, day March
year 1946 hour 9-30 P.M. minute _____ M.

21. I hereby certify that I attended the deceased from 2-11-46 to 3-14, 1946
that I last saw him alive on 3-14, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis Duration 12 Hours

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy 940

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 2

23. Signature H. R. Rosy, D.O. (M. D. or other) 3-18-46

Address Yukon, Mo Date signed 3-18-46

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

14304

307

RECEIVED
District Health Officer No. 5.
District File Number 845339
Date Filed 6-10-46

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 Gaylad Elliott
Licensed Embalmer No. 2252
P. O. Address Chapel Hill

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. MayRegistration District No. 256Primary Registration District No. 6208Registrar's No. 338

1. PLACE OF DEATH:

(a) County Texas
(b) City or town 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 _____
years, months or days)3. (a) PRINT
FULL NAME Calvin S. Chamber3. (b) If veteran, _____ 3. (c) Social Security
name war _____ No. _____4. Sex m 5. Color or race w 6. (a) Single, widowed, married,
divorced div.6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if
alive _____7. Birth date of deceased One 2 1946
(Month) (Day) (Year)8. AGE: Years 79 Months _____ Days _____ If less than one day
_____ min. _____9. Birthplace _____
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 4-15, 1946 (b) Myrtle Cray
(Date received local registrar) (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 May year 1946 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____;

that I last saw him _____ alive on _____, 19____;

and that death occurred on the date and hour stated above.

Immediate cause of death _____

Duration

Due to _____

Due to _____

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 sta-
tistically.

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 _____

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

MOTHER FATHER

SUPPLEMENTARY

15466