

No. 2
12-45
5-17-39
I X47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUN 23 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

22125

State File No. _____

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **5850**

1. PLACE OF DEATH:
(a) County **ST. LOUIS, MISSOURI**
(b) City or town **ST. LOUIS**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
7811 MINNESOTA /
(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

2. USUAL RESIDENCE OF DECEASED:
(a) State **MISSOURI** (b) County **000**
(c) City or town **ST. LOUIS** **17**
(If outside city or town limits, write "RURAL")
(d) Street No. **7811 MINNESOTA** **9**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **ROSE CHAMBERS**
3. (b) If veteran, name war **NONE** 3. (c) Social Security No. **NONE**

4. Sex **FEMALE** 5. Color or race **W**
6. (a) Single, widowed, married, divorced **WIDOWED**
6. (b) Name of husband or wife **ROBERT CHAMBERS** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **OCTOBER 25, 1877**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
69 7 18 hr. min.

9. Birthplace **IRELAND** **I**
(City, town, or county) (State or foreign country)

10. Usual occupation **NONE**

11. Industry or business _____

MOTHER FATHER { 12. Name **FRANK McALOON**
13. Birthplace **IRELAND**
(City, town, or county) (State or foreign country)

MOTHER FATHER { 14. Maiden name **JULIA McAVINDE**
15. Birthplace **IRELAND**
(City, town, or county) (State or foreign country)

16. (a) Informant **MR. PAUL CHAMBERS**

(b) Address **7811 MINNESOTA**

17. (a) **BURIAL** (b) Date thereof **6-16-47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **MT. OLIVE**

18. (a) Signature of funeral director **SOUTHERN UND. CO.**
(b) Address **6322 S. GRAND BLVD**

19. (a) **JUN 16 1947** (b) **J. J. Brebeck**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **JUNE** day **13TH**
year **1947** hour **7** minute **P.** M.

21. I hereby certify that I attended the deceased from **2 June 1, 1947** to **June 13, 1947**
that I last saw her alive on **June 13, 1947**
and that death occurred on the date and hour stated above.

Immediate cause of death **ACUTE DILATATION of heart** Duration **1 day**

Due to **Chr. Myocarditis 1 year**

Due to _____
Other conditions (Include pregnancy within 3 months of death) **92**

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)
(c) Means of injury _____

23. Signature **Owen J. M. James** (M. D. or other) **MD**
Address **7606 W. 14th** Date signed **6/14/47**

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

0589

DR. McNAMEE,
7606 MICHIGAN

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 J. Wm Dentley
Licensed Embalmer No. 13653
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.