

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **28389**
Registrar's No. **87**

FILED AUG 20 1947
Registration District No. **2/1**

Primary Registration District No. **3045-**

1. PLACE OF DEATH:
(a) County **Mississippi**
(b) City or town **Charleston**
(c) Name of hospital or institution:
800 South Main St.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **74 years**
In this community **74 years**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Mississippi**
(c) City or town **Charleston**
(If outside city or town limits, write "RURAL")
(d) Street No. **109 N. 3rd St.**
(If rural, give location)
(e) Citizen of foreign country? **No.** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Amanda Jane Chambers**
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 **Married**
6. (b) Name of husband or wife **Ben Chambers**
6. (c) Age of husband or wife if alive **83** years
7. Birth date of deceased **June 8, 1865**
(Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **July 24,** day **24th**
year **1947** hour **2:00** minute **20 A.**M.
21. I hereby certify that I attended the deceased from **Apr 22 1947** to **July 24 1947**
that I last saw him **ER** alive on **July 20 1947**
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
82 **1** **16** hr. _____ min.

Immediate cause of death **Secondary Anemia**
Due to _____
Due to **Ca of stomach**
Other condition (Include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy **no** **H. B.**

9. Birthplace **Union Co., Kentucky**
(City, town, or county) (State or foreign country)
10. Usual occupation **Retired Housewife**
11. Industry or business **None**

PHYSICIAN
Underline the cause to which death should be charged statistically.

MOTHER FATHER
12. Name **Jeff Sigler**
13. Birthplace **Kentucky**
(City, town, or county) (State or foreign country)
14. Maiden name **Priscilla Louisey**
15. Birthplace **Kentucky**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Nurtle Mooneyhan**
(b) Address **Charleston, Missouri.**
17. (a) **Burial** (b) Date thereof **7-25-1947**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Oak Grove Cenetry**

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 _____

18. (a) Signature of funeral director **Edward E. Nunneler**
(b) Address **Charleston, Missouri.**
19. (a) **8-23-47** (b) **Mrs. John Bondurant**
(Date received local registrar) (Registrar's signature)

23. Signature **E. Choate Palmer** (M. D. or other) **8/6/47**
Address **Charleston, Mo.** Date signed _____

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

District Health Office No. 2,

District File Number 847-1128

Date Filed 8-25-47

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 Edward E. Hummel

Licensed Embalmer No. 4164

P. O. Address Charleston, W. Va.

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.