

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

38582

State File No. 5224

FILED DEC 13 1952

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City	
d. FULL NAME OF HOSPITAL OR INSTITUTION K.C. Tuberculosis Hosp		d. STREET ADDRESS (If rural, give location) 7825 Wilson Ave. 56	
3. NAME OF DECEASED (Type or Print) a. (First) Minnie b. (Middle) Margaret c. (Last) Chambers			4. DATE OF DEATH (Month) (Day) (Year) 12 1 52
5. SEX Fem	6. COLOR OR RACE Wh	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 5-19-1919
9. AGE (In years last birthday) 33		IF UNDER 1 YEAR Months 0 Days 27	IF UNDER 12 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (State or foreign country) Alma Mo
12. CITIZEN OF WHAT COUNTRY? U. S.		13a. FATHER'S NAME Henry Fiene	
13b. MOTHER'S MAIDEN NAME — Vogt		14. NAME OF HUSBAND OR WIFE Ford Chambers	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 496-10-3378	
17. INFORMANT'S SIGNATURE OR NAME Ford Chambers		ADDRESS 7825 Wilson	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Tuberculosis INTERVAL BETWEEN ONSET AND DEATH *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 0024			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Nov 25 , 1952, to Dec 1 , 1952 that I last saw the deceased alive on Dec 1 , 1952, and that death occurred at 5:10 A.M. , from the causes and on the date stated above.			
23a. SIGNATURE Edward P. Altomare M.D.		23b. ADDRESS K. C. T. B. Hosp.	
23c. DATE SIGNED			
24a. PORTAL CREMATION (REMOVAL) (Specify) Burial		24b. DATE 12-3-52	
24c. NAME OF CEMETERY OR CREMATORY Woodlawn		24d. LOCATION (City, town, or county) (State) Independence Mo	
DATE REC'D BY LOCAL REG. 12-1-52		REGISTRAR'S SIGNATURE Sheraldine Smith	
FUNERAL DIRECTOR'S SIGNATURE John P. Shiel		ADDRESS 15-C. mo.	

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

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 _____

working under my personal supervision.

Student Embalmer No.

Signed.....
Student Embalmer

Signed

John P. Stahl

Licensed Embalmer No. *3625-*

P. O. Address *K C 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.