

diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. All symptoms must be listed. USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE.

REC'D JUN 7 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

18531

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **4992**

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <b>ST. LOUIS, MO.</b>		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MO</b>		a. STATE <b>ST. LOUIS, MO.</b>		b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MO</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>ST. LOUIS, MO</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>1416 Cass Av.</b>				Length of stay in lb <b>2257</b>		d. STREET ADDRESS (If outside, give location) <b>1416 CASS</b>	
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH		Month Day Year	
First <b>MARY</b>		Middle <b>NELL</b>		Last <b>CHAMBERS</b>		<b>5 24 57</b>	
5. SEX <b>FEM. 3</b>		6. COLOR OR RACE <b>COL.</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>SEPT. 23, 1905</b>	
9. AGE (In years last birthday) <b>51</b>		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>	
11. BIRTHPLACE (City and state or country) <b>YAZOO MISS</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>WEST HAMPTON</b>				14. MOTHER'S MAIDEN NAME <b>LULA FRZIER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT Address <b>Roger L. DULANEY 1410 CASS</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b>						INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						DUE TO (b)	
						DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>331x</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY. Hour a. m. p. m. Month, Day, Year							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at <b>502 A</b> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>James M. Kelly, Physician</b>				22b. ADDRESS <b>1300 Clark</b>		22c. DATE SIGNED <b>5-28-57</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>5/29/57</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GREENWOOD</b>		23d. LOCATION (City, town, or county) (State) <b>ST. LOUIS, MO. COUNTY</b>	
24. FUNERAL DIRECTOR ADDRESS <b>TRESSEH-DENT 2616 N. GARRISON.</b>			25. DATE RECD. BY LOCAL REG. <b>MAY 28 57</b>		26. REGISTRAR'S SIGNATURE <b>Earl Smith</b>		

(Licensed Embalmer's Statement on Reverse Side)

mjs

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 ....., Student Embalmer No. ....  
working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Leroy U. Gunnister*

Licensed Embalmer No. *45*

P. O. Address *4251 Wood*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.  
to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.