

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-040680  
STATE FILE NUMBER

DEC 3 1958 Registration District No. 187 Primary Registration District No. 2040 Registrar's No. 274

300  
1-57

1. PLACE OF DEATH a. COUNTY Livingston		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Livingston	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Chillicothe		c. CITY OR TOWN Chillicothe	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1218 Polk Street		d. STREET ADDRESS (If outside, give location) 1218 Polk Street	
3. NAME OF DECEASED (Type or print) First HOWARD Middle OLIVER Last CHAMBERS		4. DATE OF DEATH Month November Day 27, Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 23 April 1910
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman		10b. KIND OF BUSINESS OR INDUSTRY City Fire Dep't.	11. BIRTHPLACE (City and state or country) Gillman City, Mo.
13a. FATHER'S NAME Joseph Sherman Chambers		13b. MOTHER'S MAIDEN NAME Addie Lovell	14. NAME OF HUSBAND OR WIFE Verlene Frizzell 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. 490-10-3611	17. INFORMANT Mrs. H. O. Chambers; Chillicothe, Mo.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of right kidney (hypertension)</i> 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 (c) 180X			INTERVAL BETWEEN ONSET AND DEATH 5 years
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 _____ Month, Day, Year _____ a.m. _____ p.m. _____			
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 Nov 1952 to Nov 27-58 and last saw him alive on 11/27/58 Death occurred at four fifty-five a.m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>Mrs. M. D. Dowell, M. D.</i>		22b. ADDRESS <i>Chillicothe Mo</i>	22c. DATE SIGNED <i>11-28-58</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>11-29-58</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Edgewood</i>	23d. LOCATION (City, town, or county) (State) <i>Chillicothe, Missouri</i>
24. FUNERAL DIRECTOR ADDRESS <i>Norman Funeral Home Chillicothe, Missouri</i>		25. DATE RECD. BY LOCAL REG. <i>11/28/58</i>	26. REGISTRAR'S SIGNATURE <i>Frances B Neill</i>

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

(Licensed Embalmer's Statement on Reverse Side)

DEC 29 1958

DEC 5 1958

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 *Elton G. Norman* .....

Licensed Embalmer No. *4036* .....

P. O. Address *Chillicothe* .....

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

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