

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-001999  
STATE FILE NUMBER

Registration District No. 184 Primary Registration District No. 3038 Registrar's No. 2

300  
-57

1. PLACE OF DEATH a. COUNTY <u>Linn</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Linn</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Brookfield</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Brookfield</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT hospital, give location) HOSPITAL OR INSTITUTION <u>212 Market</u>		Length of stay in 1b <u>35 years</u>	d. STREET ADDRESS (If outside, give location) <u>212 Market</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Gertrude</u> Middle <u>Mae</u> Last <u>Chambers</u>			4. DATE OF DEATH Month <u>January</u> Day <u>7</u> Year <u>1959</u>	
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 1, 1884</u>	9. AGE (last birthday) <u>74</u>	FUNDER YEAR Months <u>6</u> Days <u>6</u>	IF UNDER 24 HRS. Hours <u>6</u> Min. <u>6</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTH PLACE (City and state or country) <u>Millister Springs, Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
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13a. FATHER'S NAME <u>Daniel Rich</u>	13b. MOTHER'S MAIDEN NAME <u>Malissa Walker</u>	14. NAME OF HUSBAND OR WIFE <u>C. B. Chambers</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>487-01-5382A</u>	17. INFORMANT <u>C. B. Chambers, Brookfield, Mo.</u> Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>chronic myocarditis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>arteriosclerosis</u> DUE TO (c) <u>Hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>18 mos.</u> <u>10 yrs.</u> <u>10 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>443x</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.)
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20c. TIME OF INJURY Hour <u>7:30</u> a.m. <u>7:30</u> p.m. <u>7:30</u>	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 <u>Brookfield</u>	COUNTY <u>Mo.</u>	STATE <u>Mo.</u>
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21. I attended the deceased from <u>1957</u> to <u>1-7-59</u> and last saw her alive on <u>1-6-59</u> Death occurred at <u>7:30 AM</u> m on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE <u>W B Simpson MD</u> (Degree or title)	22b. ADDRESS <u>Brookfield Mo</u>	22c. DATE SIGNED <u>1-8-59</u>

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Jan. 11, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	23d. LOCATION (City, town, or county) <u>Brookfield, Mo.</u>	(State)
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24. FUNERAL DIRECTOR <u>Hill Funeral Home, Brookfield, Mo.</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>1-9-59</u>	26. REGISTRAR'S SIGNATURE <u>Katharine Johnson dep</u>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

JAN 32 1959

MAY 7 1964

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 *Gerald J. Wady* .....

Licensed Embalmer No. *4174* .....

P. O. Address *Brown* .....

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.