

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-008453  
STATE FILE NUMBER

APR 6 1959 Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 326

S. 300  
1-57

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Andrew</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Joseph</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>Savannah</b> <i>cc 20</i> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Missouri Methodist Hospital</b>		Length of stay in 1b <b>2 days</b>	
3. NAME OF DECEASED (Type or print) First <b>NEAL</b> Middle <b>CHAMBERS</b> Last		4. DATE OF DEATH Month <b>March</b> Day <b>28</b> Year <b>1959</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</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>Dec. 7, 1900</b>
9. AGE (In years last birthday) <b>58</b>		10. USUAL OCCUPATION (Give kind of work done during mprt of work life, even if retired) <b>service station operator</b>	11. BIRTHPLACE (City and state or country) <b>Mt. Moriah, Missouri</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. NAME OF HUSBAND OR WIFE <b>Mrs. Lydia Chambers</b>	
13a. FATHER'S NAME <b>Otis Chambers</b>		13b. MOTHER'S MAIDEN NAME <b>Leah Catherine Allen</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>487-14-4033</b>	
17. INFORMANT <b>Mrs. Lydia Chambers</b>		Address <b>RFD #1 Savannah</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>Bilateral disarticulation of hip</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Thrombosis both femoral arteries</b> DUE TO (c) <b>Arterio sclerosis &amp; hypertension</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 hrs</b> <b>24 hours</b> <b>5 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>444X</b>		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.)	
20c. TIME OF INJURY Hour <input type="checkbox"/> Month, Day, Year a.m. <input type="checkbox"/> p.m.		20d. INJURY OCCURRED WHILE AT <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 <b>3-13-53</b> to <b>3-28-59</b> and last saw <sup>her</sup> <sub>him</sub> alive on <b>3-28-59</b> Death occurred at <b>7:55 P</b> m on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) <b>Donald Crony M.D.</b>	
22b. ADDRESS <b>Savannah Mo</b>		22c. DATE SIGNED <b>3-29-59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>		23b. DATE <b>Mar. 28, 1959</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Savannah Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Savannah, Missouri</b>	
24. FUNERAL DIRECTOR <b>Breit Funeral Home, Savannah</b>		25. DATE RECD. BY LOCAL REG. <b>Mar. 31, 1959</b>	
26. REGISTRAR'S SIGNATURE <b>Mr. Clark Stoddell</b>			

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION  
Dr. Forrest C. Long

1959

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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 *James B. Hawkins* .....  
Licensed Embalmer No. *4536* .....  
P. O. Address *General* .....

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.