

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-008438  
STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **1964**

DO NOT WRITE ON THIS STUB  
AMENDED

**FILED FEB 28 1963**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		a. STATE <b>Missouri</b> b. COUNTY	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Medical Center Hamilton Convalescent</b>		c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>EMILIE LAWRENCE WILSON CHAMBERLAIN</b>		4. DATE OF DEATH <b>February 22, 1963</b>	
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W.</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov 10 1877</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (City and state or country) <b>Baltimore, Maryland</b>
13a. FATHER'S NAME <b>James Henry Wilson (Born in Ireland, 1844)</b>		14. NAME OF HUSBAND OR WIFE <b>Wesley Alonzo Chamberlain</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		17. INFORMANT <b>Mrs. Lawrence Miller 5089 Westminister Ave.</b> Address (8)	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 + 9/12 months</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last: DUE TO (b) <b>332X</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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 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 <b>1947</b> to <b>present</b> and last saw her alive on <b>2-21-63</b> Death occurred at <b>330 A.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Robert C. Hingeland M.D.</b>		22b. ADDRESS <b>14 Foyth Walk Clayton, Mo.</b>	22c. DATE SIGNED <b>2-23-63</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Feb. 23, 1963</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis, Missouri</b>
24. FUNERAL DIRECTOR ADDRESS (12) <b>Alexander &amp; Sons, Inc. 6175 Delmar Blvd.</b>		25. DATE RECD. BY LOCAL REG. <b>FEB 25 1963</b>	26. REGISTRAR'S SIGNATURE <b>Neal Smith, M.D.</b>

VS 300 Rev. 4/59  
 1  
 2 **205**  
 3  
 4 **1**  
 5 **2**  
 6  
 7 **1**  
 8 **2**  
 9  
 10  
 11  
 12 **86-0**  
 13  
**86**  
 USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 INSTEAD OF  
 November 10, 1877  
 85  
 November 10, 1875  
 87  
 SHOULD READ  
 November 10, 1875  
 87  
 DATE AMENDED  
 4/10/63  
 4/10/63  
 Baptismal Certificate - St. Mary's church, Baltimore, Maryland 12/k/1895  
 DOCUMENT  
 BY AFFIDAVIT OF Funeral Director

MAY -3- 1963

**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 Vernon C. Vedder

Licensed Embalmer No. 5031

P. O. Address 6175 Delmar

St. Louis 12, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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

MISSOURI BOARD OF HEALTH, DEPARTMENT OF HEALTH, DIVISION OF PUBLIC HEALTH, ST. LOUIS, MISSOURI