

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

2829-63-013116
STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **2829**

DO NOT WRITE ON THIS STUB
AMENDED

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS (INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

FILED MAR 20 1963		1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in-1b 35 Yrs		c. CITY OR TOWN Wellston Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF HOSPITAL OR INSTITUTION St. Anthonys Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 6409 Lenox Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CORBET LELAND CHUMLEY			4. DATE OF DEATH Month March Day 9 Year 1963		
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 3/20/1906	9. AGE (last birthday) 56	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mill operator		10b. KIND OF BUSINESS OR INDUSTRY Johnson's Foil & Metal		11. BIRTHPLACE (City and state or country) Steeleville, Mo	
12. CITIZEN OF WHAT COUNTRY USA		13a. FATHER'S NAME William O. Chumley		13b. MOTHER'S MAIDEN NAME Myrtle Snoddy	
13c. NAME OF HUSBAND OR WIFE Mrs. Mary Artur Chumley		14. SOCIAL SECURITY NO. 332x		17. INFORMANT Address 6409 Lenox	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of servi no		18. CAUSE OF DEATH (Enter only one cause per line PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage Cerebral Thrombosis Pulmonary Embolism 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)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input 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 s.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 Dec 10 1962 to March 9-1963 and last saw her/him alive on March 9 1963 Death occurred at 98 9A: m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE H. J. Moore M.D. (Degree or title)		22b. ADDRESS 917-5018		22c. DATE SIGNED 3-11-1963	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 3/12/1963		23c. NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery	
23d. LOCATION (City, town, or county) St. Louis County, Mo		24. FUNERAL DIRECTOR Alexander & Sons		25. DATE RECD. BY LOCAL REG. MAR 11 1963	
24. ADDRESS 6175 Delmar Blvd		26. REGISTRAR'S SIGNATURE Coal Smith. M.D.			

USE BLACK INK OR TYPEWRITER RIBBON

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Dr. Harry Moore

921 So 18th

GA 1-0650

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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

J. Allen Davis

Licensed Embalmer No. *405B*

P. O. Address *ATL*

March 9-63

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.