

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-046901
STATE FILE NUMBER

Registration District No. 10 Primary Registration District No. 3002 Registrar's No. 1

FILED DEC 20 1963

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| DO NOT WRITE ON THIS STUB | AMENDED | | | | |
| VS 300 Rev. 4/59 | DATE AMENDED | | | | |
| 1 <u>0047</u> | | | | | |
| 2 <u>0101</u> | | | | | |
| 3 | | | | | |
| 4 <u>1</u> | | | | | |
| 5 <u>0</u> | | | | | |
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| 7 <u>0</u> | | | | | |
| 8 <u>0</u> | | | | | |
| 9 <u>762.0</u> | | | | | |
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| 12 <u>90-1</u> | | | | | |
| 13 <u>30</u> | | | | | |
| AMENDMENTS ON THIS RECORD ARE AS FOLLOWS | INSTEAD OF | | | | |
| BY AFFIDAVIT OF | DOCUMENT | | | | |
| SHOULD READ | | | | | |
| ITEM NO. | | | | | |

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|---|--|--|--|--|--|
| 1. PLACE OF DEATH | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) | | | |
| a. COUNTY <u>Boone</u> Audrain | | a. STATE <u>Mo</u> | | b. COUNTY <u>Boone</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Centralia</u> Mexico | | Length of stay in 1b <u>25 days</u> | | c. CITY OR TOWN <u>Centralia</u> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Audrain County</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) <u>314 West Railroad</u> | |
| 3. NAME OF DECEASED | | 4. DATE OF DEATH | | 5. SEX | |
| First Middle Last <u>Christe Lea Chamberlain</u> | | Month Day Year <u>Dec. 13 1963</u> | | <u>Female</u> | |
| 6. COLOR OR RACE <u>Caucasian</u> | | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Nov. 18 '63</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ----- | | 10b. KIND OF BUSINESS OR INDUSTRY ----- | | 9. AGE (last birthday) Months <u>25</u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 11. BIRTHPLACE (City and state or country) <u>Centralia, Mo.</u> | | 12. CITIZEN OF WHAT COUNTRY <u>USA</u> | | | |
| 13a. FATHER'S NAME <u>Edgar Don Chamberlain</u> | | 13b. MOTHER'S MAIDEN NAME <u>Barbara Kotowicz</u> | | 14. NAME OF HUSBAND OR WIFE ----- | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown. If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. [REDACTED] | | 17. INFORMANT Address <u>E.D. Chamberlain, Centralia, Mo.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line) | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: | | | | | |
| IMMEDIATE CAUSE (a) <u>Sudden respiratory arrest due to undetermined cause with anoxemia and cardiac arrest</u> | | | | | |
| 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 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. 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 <u>11-18-63</u> to <u>12-13-63</u> and last saw her alive on <u>12-13-63</u> Death occurred at <u>12:10</u> a.m. on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE <u>Ray L. Ward MD</u> (Degree or title) | | | 22b. ADDRESS <u>Centralia, Missouri</u> | | 22c. DATE SIGNED <u>12-13-63</u> |
| 23a. BURIAL, CREMATION OR REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| <u>Burial</u> | | <u>Dec. 14, 1963</u> | | <u>Glendale Memorial Gardens</u> | |
| 24. FUNERAL DIRECTOR <u>Bud J. Meadows</u> | | ADDRESS <u>Centralia, Missouri</u> | | 25. DATE RECD. BY LOCAL REG. <u>December 16-1963</u> | |
| 26. REGISTRAR'S SIGNATURE <u>Alberta Edmonston</u> | | | | | |

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK OR TYPEWRITER RIBBON

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 B. J. Meador

Licensed Embalmer No. 4876

P. O. Address Centralia, Missouri

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.