

FILED MAR 7 - 1940

Registration District No. 73

Primary Registration District No. 3-10-2

Registrar's No. 33

1. PLACE OF DEATH:

(a) County Boone
(b) City or town Boone Station
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Rural
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution all of life (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Boone
(c) City or town Boone Station
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

8. (a) PRINT FULL NAME Samuel V. Chandler, 534
8. (b) If veteran, name war None 3. (c) Social Security No. None

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Feb day 9
year 1940 hour 12:00 minute 00 M.

4. Sex Male 5. Color or race W 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Fannie Frances Chandler 6. (c) Age of husband or wife if 66 years
7. Birth date of deceased: (Month) 9 (Day) 1873 (Year) 1873

21. I hereby certify that I attended the deceased from 2-7-
1940 to Feb 7, 1940
that I last saw him alive on 2-7-40
and that death occurred on the date and hour stated above.

8. AGE: Years 66 Months 5 Days ? If less than one day: hr. _____ min. _____

Immediate cause of death Apoplexy Direction _____

9. Birthplace Boone County Mo.
(City, town, or county) (State or foreign country)

Due to High Blood pressure
Due to Bright's disease

10. Usual occupation Farmer

Other conditions that I know
(Include pregnancy within 3 months of death)

11. Industry or business _____
12. Name W. H. Chandler
13. Birthplace Boone County Mo.
(City, town, or county) (State or foreign country)
14. Maiden name WELBIA ROBERT
15. Birthplace Boone County Mo.
(City, town, or county) (State or foreign country)

Major findings: _____
Of operations _____
Of autopsy no PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. Brown
(b) Address Boone Station, Mo.

22. If death was due to external causes, fill in the following: _____
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

17. (a) Burial (b) Date thereof 2-10-40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Red Top Cem.

23. Signature F. J. Williams (M. D. or other) _____
Address Columbia Mo Date signed 2-9-40
While at work? _____ (Specify type of place) (e) Means of injury _____

18. (a) Signature of funeral director Harker
(b) Address Columbia, Mo.
19. (a) 2/10/40 (b) Allie Selby
(Date received local registrar) (Registrar's signature)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

8241

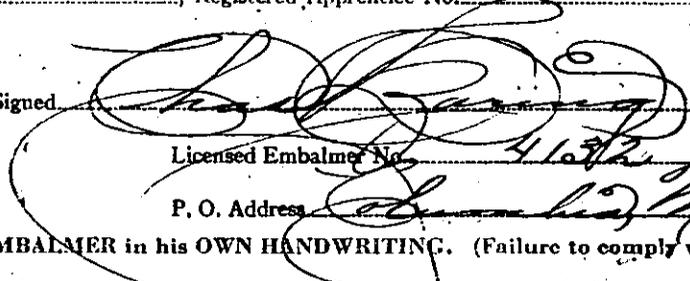
11.60

11.60

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.....
....., Registered Apprentice No.
working under my personal supervision.

Signed


.....
Licensed Embalmer No. 41072

P. O. Address

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 this body is not embalmed, above space should be left blank.

S. No. 7B
1-221-40
X22659

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 3909

Registration District No. 13

Primary Registration District No. 5112

Registrar's No. 33

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Boone

(b) City or town Columbia Mo
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether)

In this community _____ (Specify whether)

years, months or days

3. (a) PRINT FULL NAME Samuel V Chandler

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex m

5. Color or race w

6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife _____

6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 66 Months 5 Days -

If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

MOTHER FATHER { 12. Name

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

17. (a) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____ (If outside city or town limits write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Feb day 9 year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw h_____ alive on _____, 19____;

and that death occurred on the date and hour stated above.

Immediate cause of death apoplexy

Due to High Blood Pressure

Bright Disease

Cholera

Due to _____

Other conditions not known
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) _____ (e) Means of injury _____

23. Signature F. B. Williamson (M. D. or other) _____

Address Columbia Mo Date signed _____

SUPPLEMENTAL

