

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH  
1003

503

State File No. \_\_\_\_\_

Registrar's No. **503**

Registration District No. **791**

Primary Registration District No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town St. Louis, Missouri  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: St. Louis Children's Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 13 days  
(Specify whether  
In this community \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME HAROLD ARNOLD CHANDLER

3. (b) If veteran, name war no. 3. (c) Social Security No. none

4. Sex M 5. Color or race W/O 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Chiel 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased 10 8 36  
(Month) (Day) (Year)

8. AGE: Years 4 Months 3 Days 8 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Vandalia 1 Illinois  
(City, town, or county) (State or foreign country)

10. Usual occupation Chiel

11. Industry or business \_\_\_\_\_

12. Name Harold Chandler

13. Birthplace 2 1 Illinois  
(City, town, or county) (State or foreign country)

14. Maiden name Gladys Arnold

15. Birthplace 1 Illinois  
(City, town, or county) (State or foreign country)

16. (a) Informant Patricia Moore  
(b) Address St. Louis Children's Hospital

17. (a) Removal (b) Date thereof 1-17-41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Pataoka, Ill.

18. (a) Signature of funeral director Robert H. Hooper  
(b) Address 4700 Washington Ave.

19. (a) \_\_\_\_\_ (b) J. W. Brederick  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County Marion  
(c) City or town Pataoka  
(If outside city or town limits, write "RURAL") N.R. 11  
(d) Street No. RR # 1  
(If rural, give location) 0  
(e) If foreign born, how long in U. S. A? 2 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 16  
year 41 hour 12 minute 12 P.M.

21. I hereby certify that I attended the deceased from 1-16 to 1-16, 1941.  
that I last saw him alive on 1-16, 1941.  
and that death occurred on the date and hour stated above.

Immediate cause of death Circulatory collapse occurring during an acute exacerbation of hypertrophic cardiomyopathy  
Due to \_\_\_\_\_

Due to MI  
Other conditions Heart disease into small intestine  
(Include pregnancy within 3 months of death)

Major findings: Of operations MI  
Of autopsy Splenomegaly, hemorrhage into small intestine, leukemic infiltration of lymph nodes

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 SI (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature R. D. Bluthner (M.D. or other) \_\_\_\_\_  
Address 1005 S. Kings St. St. Louis Date signed \_\_\_\_\_

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

00  
17  
9

MOTHER FATHER

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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.....

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

Signed..... *Gay W Wilkerson*

Licensed Embalmer No..... *3575*

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, fact should be so stated above.**