

S. No. 2
M-2-43
5-17-39
I-X35897

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 36224

FILED DEC 9 1943
318
Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 10199

1. PLACE OF DEATH:
(a) County St. Louis, Mo.
(b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Homer G. Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 days
Life (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St. Louis
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 4202 West Belle
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country No

3. (a) PRINT FULL NAME Thomas Chandler
3. (b) If veteran, name war No
3. (c) Social Security No. No

4. Sex Male
5. Color or race Colored
6. (a) Single, widowed, married, divorced, widower Widower
6. (b) Name of husband or wife None
6. (c) Age of husband or wife if alive None years

7. Birth date of deceased July 23, 1889
(Month) (Day) (Year)

8. AGE: Years 54 Months 3 Days 11
If less than one day hr. min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER
12. Name Thomas Chandler
13. Birthplace Unknown 9
(City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown 9
(City, town, or county) (State or foreign country)

16. (a) Informant Shirley M. Smith
2601 N. Whittier St.

(b) Address _____
17. (a) Washington
(Burial, cremation, or removal) (b) Date thereof 11-8-43
(Month) (Day) (Year)

(c) Place: burial or cremation Washington

18. (a) Signature of funeral director W. K. Kellon
(b) Address 3500 Rutledge

19. (a) NOV 30 1943
(Date received local registrar) (b) J. J. Muller
(Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month November day 3,
year 1943 hour 4 minute 20 A. M.

21. I hereby certify that I attended the deceased from October 29, 1943 November 3, 1943
that I last saw him alive on November 3, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Chr. Bronchitis
Duration Unknown

Due to _____
Due to _____
Other conditions (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 _____

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)
(c) Means of injury _____

23. Signature S. E. Smith (M. D. or other)
Address 2601 Whittier Date signed 11/10/43

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

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.....

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.