No. 300
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED SEP 24 1948

Registration District No. 18

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 30900

Registrar's No. 7971

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis (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 2 weeks (Specify whether years, months or days)

In this community 50 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

(c) City or town St. Louis (If outside city or town limits, write "RURAL")

(d) Street No. 4320a Maffitt Avenue (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Albert Chandler

3. (b) If veteran, name war WORLD #1

3. (c) Social Security No. 499-05-5903

4. Sex Male

5. Color or race Negro

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

6. (b) Name of husband or wife Alberta Chandler

6. (c) Age of husband or wife if alive 54 years

7. Birth date of deceased November 10, 1894 (Month) (Day) (Year)

8. AGE: Years 53 Months 9 Days 27 If less than one day hr. min.

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

10. Usual occupation Laborer

11. Industry or business Park Dept.

MOTHER FATHER

12. Name John Chandler

13. Birthplace St. Charles Co, Mo. (City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace St. Charles Co., Mo. (City, town, or county) (State or foreign country)

16. (a) Informant Alberta Chandler

(b) Address 4320a Maffitt Avenue

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-13-1948 (Month) (Day) (Year)

(c) Place: burial or cremation National Cemetery

18. (a) Signature of funeral director Chas. J. Gates

(b) Address 4107 Finney Avenue

19. (a) SEP 11 1948 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September Day 7th year 1948 hour 10 minute 20 A.M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw him alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death Fracture of Skull, Sub Dural Hematoma, Whether the result of a fall or altercation could not be determined

Due to

Other conditions (Include pregnancy within 3 months of death) None

Major findings: Of operations None

Of autopsy None

Duration

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) Open Verdict

(b) Date of occurrence Unknown

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

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Unknown (Specify type of place)

While at work? (e) Means of injury See above

23. Signature Alfred Gleeson (M. D. or other)

Address 1300 Market Avenue Date signed 9/11/48

(Licensed Embalmer's Statement on Reverse Side)

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 John K. Cunningham, Registered Apprentice No. _____, working under my personal supervision.

Signed John K Cunningham

Licensed Embalmer No. 4476

P. O. Address 4107 Finney Avenue

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.