WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1 PLACE OF DEATH

County: Henry

Township: ~~Windsor~~ or Village ...... or City: Windsor (NO. ...... St., ... Ward)

Registration District No. 14

Primary Registration District No. 4211

File No. [redacted]

Registered No. 29 31687

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME John S. Chandler

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: June (Month) 10 (Day), 1862 (Year)

7 AGE: 55 yrs. 3 mos. 15 ds. — If LESS than 1 day, ... hrs. or ...... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Farmer & Stockman
(b) General nature of industry, business, or establishment in which employed (or employer): Good

9 BIRTHPLACE (City or town, State or foreign country): Boon Co. Mo.

PARENTS

10 NAME OF FATHER: John Chandler

11 BIRTHPLACE OF FATHER (City or town, State or foreign country): K.Y.

12 MAIDEN NAME OF MOTHER: Jane Lane

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): K.Y.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. P. Baumgartner

(Address) Santa Anna Calif.

15 Filed Sept 26, 1917 B. F. Jennings, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Sept (Month) 25 (Day), 1917 (Year)

17 I HEREBY CERTIFY, that I attended deceased from — 191..., to — 191..., that I last saw h— alive on — 191..., and that death occurred, on the date stated above, at 10 40 a.m.

The CAUSE OF DEATH* was as follows:

Accidental death caused by being run over by M K & T Freight train.

2076 (Duration) ...... yrs. ...... mos. ...... ds.

CONTRIBUTORY (Secondary) 175

(Duration) ...... yrs. ...... mos. ...... ds.

(Signed) W. McCall, M. D.

Sept 25, 1917 (Address) Windsor Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ...... yrs. ...... mos. ...... ds. In the State ...... yrs. ...... mos. ...... ds.

Where was disease contracted if not at place of death? ......

Former or usual residence ......

19 PLACE OF BURIAL OR REMOVAL: Columbia Mo. — DATE OF BURIAL: Sept. 26, 1917

20 UNDERTAKER: W. E. Heaton — ADDRESS: Windsor Mo.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

WRITE PLAINLY with UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1 PLACE OF DEATH

County .....

Township ..... Registration District No. ..... File No. .....
or
Village ..... Primary Registration District No. ..... Registered No. .....
or
City ..... (NO. ....., ... St.; ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (*Write* the word)

6 DATE OF BIRTH

..... (Month) ..... (Day), 1..... (Year)

7 AGE

.....yrs. .....mos. .....ds.

If LESS than 1 day, ...hrs. or .....min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry business or establishment in which employed (or employer) .....

9 BIRTHPLACE
(City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town, State or foreign country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed ....., 191..... .....
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

..... (Month) ..... (Day), 191..... (Year)

17 I HEREBY CERTIFY, that I attended deceased from ....., 191....., to ....., 191.....,

that I last saw h.....alive on ....., 191.....,

and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY .....
(Secondary)

..... (Duration) .....yrs. .....mos. .....ds.

(Signed) ..... M. D.

....., 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ....., 191.....
20 UNDERTAKER	ADDRESS