

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

Do not use this space.

12941

1. PLACE OF DEATH

County Jackson
Township Kanawha
City Kanawha City

Registration District No. 399
Primary Registration District No. 1982
(No. St. Mary's Hospital)

File No. _____
Registered No. 1870
St. _____ Ward)

2. FULL NAME

William W. Chandler

(a) Residence. No. _____ St. _____ Ward. _____
(Usual place of abode)

Shreveport Louisiana
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. If MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) August 18-1872

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
57 8 12

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Railroad Conductor
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Mississippi

10. NAME OF FATHER

J. Chandler

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Virginia

12. MAIDEN NAME OF MOTHER

May Kent

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Tennessee

14. INFORMANT

Mrs. Della Chandler
(Address) Shreveport Louisiana

15. FILED

4/30 1930 M. M. Croove
REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 30 1930

17. I HEREBY CERTIFY, That I attended deceased from _____ 1930, to 4-30 1930, that I last saw him alive on 4-30, and that death occurred, on the date stated above, at 12:30 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Coronary atherosclerosis
chronic myocarditis

936
94B (duration) 2 yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

infarction

(duration) _____ yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH, _____

DID AN OPERATION PRECEDE DEATH? 0 DATE OF _____

WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) W. J. M. C., M. D.

4/30, 1930 (Address) 17 Ave. D.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

Winona Mississippi

DATE OF BURIAL

5-3 1930

20. UNDERTAKER

Thos J. Sheehan

ADDRESS

K. P. Mo

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.

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WRITE PLAINLY WITH CARE AND INK THIS IS A PERMANENT RECORD

