

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

Do not use this space.

1199

1. PLACE OF DEATH

County Jackson
Township 12th ass
City Paris City

Registration District No. 399
Primary Registration District No. 1002
(No. General Hospital # 2)

File No. _____
Registered No. 237
St. _____ Ward _____

2. FULL NAME

Infant Chandler
(a) Residence. No. 579 Front Ave St. _____ Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>Colored</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Newborn</u>
-------------------------	------------------------------------	--

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan. 9, 1932

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
			<u>2</u>	

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) Kansas City, Mo.
(STATE OR COUNTRY)

PARENTS	10. NAME OF FATHER <u>Lewis Chandler</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) <u>Unknown</u> (STATE OR COUNTRY) <u>31</u>
	12. MAIDEN NAME OF MOTHER <u>Mamie Blakes</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) <u>La</u> (STATE OR COUNTRY) <u>2</u>

14. INFORMANT Record Clerk
(Address) Gen Hospital # 2

15. FILED Jan 21 32 M. M. Cronin
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan. 11, 1932

17. I HEREBY CERTIFY, That I attended deceased from Jan. 9, 1932, to Jan. 11, 1932 that I last saw him alive on Jan. 11, 1932, and that death occurred, on the date stated above, at 6:59 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Hemorrhage of the Newborn
159
161D (duration) _____ yrs. _____ mos. _____ ds.
CONTRIBUTORY (SECONDARY) Prematurity (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED 159
IF NOT AT PLACE OF DEATH (1)

DID AN OPERATION PRECEDE DEATH? No DATE OF _____
WAS THERE AN AUTOPSY? Yes
WHAT TEST CONFIRMED DIAGNOSIS? Clinical & postmortem
(Signed) D. M. Miller, M. D.
12, 1932 (Address) General Hospital # 2

*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 <u>Seeds rd</u>	DATE OF BURIAL <u>1-21 1932</u>
---	------------------------------------

20. UNDERTAKER <u>H.B. Moore</u>	ADDRESS <u>1820 E. 11th</u>
-------------------------------------	---

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.

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

