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.

SEP 6 1934

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

Do not use this space.

File No. 28916

Registered No.

1. PLACE OF DEATH
County: Greene
Township: ~~Boone~~
City: Ash Grove, (No. ..., ... St. ... Ward)
Registration District No. 316
Primary Registration District No. 4191

2. FULL NAME: Roxie J. Chandler.
(a) Residence, No. ... Ash Grove, Mo. St., ... Ward.
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Widow

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF (OR) WIFE OF: W. T. Chandler

6. DATE OF BIRTH (MONTH, DAY, AND YEAR): 5/14/1861

7. AGE: Years 73 | Months 2 | Days 25 | If LESS than 1 day, ... hrs. or ... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.: House Wife
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.: of Merchant
10. Date deceased last worked at this occupation (month and year):
11. Total time (years) spent in this occupation:

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Indiana

FATHER
13. NAME: William Comegys
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Indiana

MOTHER
15. MAIDEN NAME: Eliza Triece
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Indiana

17. INFORMANT (ADDRESS): T. K. Chandler, Ash Grove, Mo.

18. BURIAL, ~~CREMATION OR REMOVAL~~
PLACE: Ash Grove Mo. DATE: 8/10/34, 19
Burial

19. UNDERTAKER (ADDRESS): A. Galbraith, Ash Grove

20. FILED: 8/10, 1934 Mrs Leonard Jones, Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): 8/9/34, 19

22. I HEREBY CERTIFY, That I attended deceased from Aug 6, 1934, to Aug 9, 1934, 19
I last saw her alive on Aug 9, 1934. Death is said to have occurred on the date stated above, at 2:10 P.M.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Cerebral Embolism	Aug 6, 34
Coma	
Fever	
Coma	
Other contributory causes of importance:	
Previous Embolism - 1933	
Chronic Valvular Heart Disease	

Name of operation: None, Date of
What test confirmed diagnosis? Clinical Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury, 19
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify
(Signed) Dr Charles L Dry, M. D.
(Address) Ash Grove Mo.