

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

36207
Do not use this space.

1939 NOV 24 1939

1. PLACE OF DEATH *2*

(a) County *Lickery* Registration District No. *360*

(b) Township *Center* Primary Registration District No. *5505* Registered No. *4*

(c) City *Hermitsburg* (d) Street No. _____ (If death occurred in Hospital or Institution, write its name instead of street and number) St.

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

2. PRINT FULL NAME *534 Joseph M. Chandler*

(a) Residence, No. _____ St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *m* 4. COLOR OR RACE *wh.* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *widower*

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Oct 21, 1869*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. *69 - 15*

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *Farmer*

9. Industry or business in which work was done, as saw mill, bank, etc. *Farmer*

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) *Springfield Mo*

FATHER 13. NAME *Henry R. Chandler*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Tenn*

MOTHER 15. MAIDEN NAME *Olga E. McKee*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Tenn*

17. INFORMANT (ADDRESS) *Sally Gaba Spg-Mo*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Springfield* DATE *Oct 7 1939*

19. FUNERAL DIRECTOR (ADDRESS) *Wheatland Mo*

20. FILED *Oct 7 1939* *Anice McKenley* Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Oct 6 1939*

22. I HEREBY CERTIFY, That I attended deceased from *Sept 1 - 1939*, to *Oct 6 - 1939*

I last saw him alive on *Sept 25 - 1939*. Death is said to have occurred on the date stated above, at *7:00 a* m.

The principal cause of death and related causes of importance were as follows:
Chronic interstitial Nephritis Date of onset *Unknown*

Other contributory causes of importance:
Chronic Cystitis and Prostatitis *Aug 1939*

Name of operation *None* Date of _____

What test confirmed diagnosis? *Laboratory* 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) *A. S. Johnston*, M. D.
321 (Address) *Wheatland, Mo*

WHITE 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.

RECEIVED

District Health Officer No. 7,

District File Number 11-39-1260

Date Filed 11-7-39

STATEMENT BY LICENSED EMBALMER

I, JR Luckey, Licensed Embalmer No. 2982

hereby certify that the body recorded on the reverse side of this certificate was embalmed by

.....
L. E.

No. or by Registered Apprentice No.

working under my personal supervision.

Signed JR Luckey
Licensed Embalmer No. 2982

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.)