

JAN 8 1940

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

43427  
Do not use this space.

1. PLACE OF DEATH  
 (a) County GREENE 3 Registration District No. 322  
 (b) Township Franklin 1 Primary Registration District No. 5446 Registered No. 23  
 or SPRINGFIELD  
 (c) City SPRINGFIELD (d) Street No. Fair Grove R-1 St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (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 WILLIAM GRANT CHANDLER  
 (a) Residence, No. Willard R-1 St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (Use only one word) Child

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept-19-1939

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
3 5

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
 9. Industry or business in which work was done, as saw mill, bank, etc. Child  
 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) Willard Mo

FATHER  
 13. NAME Ray Chandler  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Cave Springs Mo

MOTHER  
 15. MAIDEN NAME Esther Buckner  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Fair Grove Mo

17. INFORMANT (ADDRESS) Ray Chandler Willard Mo R-1

18. BURIAL, CREMATION, OR REMOVAL  
 PLACE Rose Hill DATE 12 26 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Quinn Funeral Home Springfield Mo

20. FILED Dec 28 1939 Allan Barnes Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 25, 1939

22. I HEREBY CERTIFY, That I attended deceased from Dec 25, 1939 to Dec 25, 1939, 1939  
 I last saw him/her on Dec 25, 1939 Death is said to have occurred on the date stated above, at 5:30 a.m.  
 The principal cause of death and related causes of importance were as follows:  
Intermittent Pneumonia Date of onset 1 week  
10 days  
 Other contributory causes of importance:  
Pneumonia  
10 days to 14 days before death  
3 months before

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

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? \_\_\_\_\_  
 (If so, specify \_\_\_\_\_)  
 (Signed) Alfred White M. D.  
Quinn Funeral Home  
Springfield 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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**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....  
....., Registered Apprentice No.....  
..... working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**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.)**

**If this body is not embalmed, above space should be left blank.**