

FILED DEC 3 1943

Registration District No. 749

Primary Registration District No. 1002

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City Mo.  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Joseph Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 Months  
(Specify whether years, months or days)

In this community 2 Months

3. (a) PRINT FULL NAME ALVIN CHANDEL

3. (b) If veteran, name war None

3. (c) Social Security No. No.

4. Sex Female / 5. Color or race White

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife \*\*\*\*\*

6. (c) Age of husband or wife if alive \*\*\*\*\* years

7. Birth date of deceased April 14th 1904  
(Month) (Day) (Year)

8. AGE: Years 39 Months 6 Days 25  
If less than one day hr. min.

9. Birthplace St. Louis Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business Bookkeeper

12. Name Jacob Handel

13. Birthplace Youngstown Ohio  
(City, town, or county) (State or foreign country)

14. Maiden name Margaret Mockeer

15. Birthplace St. Louis Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Miss Marie Handel.

(b) Address St. Louis Missouri

17. (a) Removal (b) Date thereof 11/9/43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Tower Grove Missouri

18. (a) Signature of funeral director Melody-McGilley.

(b) Address K. C. Mo.

19. (a) 11-9-43 (b) T. E. Brown  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

(c) City or town St. Louis Missouri  
(If outside city or town limits, write "RURAL")

(d) Street No. 3519A. Lawn  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 9  
year 1943 hour 1 minute 5 a.m.

21. I hereby certify that I attended the deceased from 9/11 1943 to 11/9 1943  
that I last saw h. er alive on 11/8 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Uremia

Due to Renal Tuberculosis

Due to Pulmonary Tuberculosis

Other conditions (include pregnancy within 3 months of death) 13 1/2

Major findings: Of operations Renal Tuberculosis

Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)

(c) Means of injury \_\_\_\_\_

23. Signature T. E. Brown (M. D. or other) 11/9/43  
Address 1103 Grand Ave Date signed \_\_\_\_\_

Duration

4 mos

Known at death

8 yrs

PHYSICIAN

Underline the cause to which death should be charged statistically.

JAN 7 1944

JAN 2 0 1944

DEC. 28 1944

**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. 2788  
P. O. Address..... EC

**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, fact should be so stated above.**