

FILED JUL 15 1944

State File No. \_\_\_\_\_

Registration District No. 317

Primary Registration District No. 2002

Registrar's No. 1486

1. PLACE OF DEATH:

(a) County St. Louis,  
(b) City or town University City,  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
6335 Waterman Ave.,  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether  
In this community 50 years  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis,  
(c) City or town University City,  
(If outside city or town limits, write "RURAL")  
(d) Street No. 6335 Waterman Ave.,  
(If rural, give location)  
(e) Citizen of foreign country? No. (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Marie L. Chandler,

3. (b) If veteran, name war None 3. (c) Social Security No. none

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 December 6, 1871  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>72</u>	<u>7</u>	<u>4</u>	_____ hr. _____ min.

9. Birthplace Unknown Virginia  
(City, town, or county) (State or foreign country)

10. Usual occupation None

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Samuel T. Chandler,  
13. Birthplace Unknown Virginia  
(City, town, or county) (State or foreign country)  
14. Maiden name Reubenia Grigsby  
15. Birthplace Unknown Virginia  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Anna R. Dubach  
(b) Address 6335 Waterman Ave.,

17. (a) burial (b) Date thereof 7/12/44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bellefontaine Cem.

18. (a) Signature of funeral director Wagoner Mortuary

(b) Address 4164 Lindell Blvd.

19. (a) JUL 12 1944 (b) E. S. McKeever, M.D.  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 10<sup>th</sup>  
year 1944 hour 16 minute 10 A.M.

21. I hereby certify that I attended the deceased from June 1944 to July 19 1944

that I last saw her alive on July 8 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage with hemiplegia  
Due to gen. arterio sclerosis Duration 2 d. 10 + yrs

Other conditions Congenital heart disease 72 yrs  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_ Of autopsy 1572  
PHYSICIAN \_\_\_\_\_ Underline the cause to which death should be charged statistically.

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? \_\_\_\_\_

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

23. Signature John L. Horner (M. D. or other) M.D.  
Address 114 N. Taylor St. Louis Date signed 7-10-44

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

SEP 28 1944

HPPI

HP  
PP

B  
CI

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 Neville B. Frohwitter

Licensed Embalmer No. 3696

P. O. Address 416 Lindell

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.