No. 2
4-13-40
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I X23159

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUL 7 1945

Registration District No. 40

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 19829

Primary Registration District No. 5-1-22-4051

Registrar's No.

1. PLACE OF DEATH:
(a) County Boone
(b) City or town Hallsville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community all his Life
years, months or days)

2. USUAL RESIDENCE OF DECEASED: 10
(a) State (b) County 0
(c) City or town 0
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME GEORGE W. CHANDLER
3. (b) If veteran, name war —
3. (c) Social Security No. —
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Bessie Chandler
6. (c) Age of husband or wife if alive 64 years
7. Birth date of deceased Dec. (Month) 1 (Day) 1864 (Year)

8. AGE: Years 80 Months 7 Days 3 If less than one day hr. min.

9. Birthplace Boone Co. (City, town, or county) Missouri (State or foreign country)
10. Usual occupation Retired Mail carrier
11. Industry or business Retired
FATHER
12. Name Carter Chandler
13. Birthplace (City, town, or county) Ky. (State or foreign country) 1
MOTHER
14. Maiden name Eliza Wolf
15. Birthplace (City, town, or county) Ky. (State or foreign country) 1
16. (a) Informant Lottie May Fulkerson
(b) Address Columbia Mo. 319 Sexton
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7 (Month) 6 (Day) 1945 (Year)
(c) Place: burial or cremation Memorial Park Cemetery
18. (a) Signature of funeral director Parker Funeral Service
(b) Address Columbia Missouri
19. (a) July 5 1945 (Date received local registrar) (b) Ruby West (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 4
year 1945 hour 1 minute 20 P.M.
21. I hereby certify that I attended the deceased from June 15, 1945, to July 4, 1945;
that I last saw him alive on July 3, 1945;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Acute Myocardial Degeneration	2 days
Due to Chronic Hypertension Heart disease	15 yrs.
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy 930

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? (e) Means of injury
23. Signature R. P. Roberts 2 (M.D. or other) DO
Address Centralia, Mo Date signed 7-4-45

1078

(Licensed Embalmer's Statement on Reverse Side)

AUG 20 1945

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 W. W. Williams

Licensed Embalmer No. 3893

P. O. Address Columbia m

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

S. No. 2B
M—3-45
1 X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. J-u-1-y-

Registration District No. 40 Primary Registration District No. 4051 Registrar's No.

1. PLACE OF DEATH:

(a) County Boone

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

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

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Boone

(c) City or town Hallsville
(If outside city or town limits, write "RURAL")

(d) Street No. Depot St.
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME George W. Chandler

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased Dec (Month) 1 (Day) 1864 (Year)

8. AGE: Years 80 Months Days 3 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) Ruby West (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Jul Day 4
year 1945 hour minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ;
that I last saw him alive on , 19 ;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

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? (e) Means of injury

23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

5-19829