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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 16 1947

Registration District No. 3177

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 6076

State File No. 3451

Registrar's No. 4

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

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town City of Ladue
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 15 Warson Terrace
(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 96
(c) City or town City of Ladue 12
(If outside city or town limits, write "RURAL")
(d) Street No. 15 Warson Terrace 1
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Warren Moore Chandler
3. (b) If veteran, name war None
3. (c) Social Security No. none
4. Sex Male
5. Color or race white
6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife Edna Shaw Chandler
6. (c) Age of husband or wife if alive ..... years
7. Birth date of deceased October (Month) 3rd (Day) 1865 (Year)

8. AGE: Years 81 Months 3 Days 0 If less than one day ..... hr. ..... min.

9. Birthplace Rockbridge County (City, town, or county) Virginia (State or foreign country)
10. Usual occupation Retired Banker
11. Industry or business
FATHER
12. Name Samuel Temple Chandler
13. Birthplace (City, town, or county) Virginia (State or foreign country)
MOTHER
14. Maiden name Rubenia Grigsby
15. Birthplace (City, town, or county) Virginia (State or foreign country)
16. (a) Informant Warren T. Chandler
(b) Address 51 Westmoreland Place
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 4th '47 (Month) (Day) (Year)
(c) Place: burial or cremation Bellefontaine
18. (a) Signature of funeral director Wagoner Mortuary
(b) Address 4161 Lindell Blvd
19. (a) 1-7-47 (Date received local registrar) (b) Ruth G. Allen MD (Registrar's signature) MSO

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 3
year 1947 hour 5 minute A M.
21. I hereby certify that I attended the deceased from May 1939
, 19 , to Jan. 3 1947
that I last saw him alive on Jan. 2 1947
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cerebral hemorrhage	3 days
Due to Hypertensive heart disease	10 yrs.
Due to Arteriosclerosis generalized	15 yrs
Other conditions Parkinson's disease (Include pregnancy within 3 months of death)	5 yrs.

Major findings:
Of operations 93d
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 H. G. Newman (M. D. or other) MD
Address 3720 Washington Date signed 1/3/47

(Licensed Embalmer's Statement on Reverse Side)

Dr. Harold Newman
3720 Washington Ave
1 — 4 P.M.

FEB 3 1947

FEB 10 1947

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. Grokowitter

Licensed Embalmer No. 3696

P. O. Address 4161 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.