

FILED MAR 29 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

9435

STATE FILE NUMBER

 Registration District No. 217 Primary Registration District No. 3045 Registrar's No. 23

1. PLACE OF DEATH a. COUNTY <b>Mississippi</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Mississippi</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Charleston</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Charleston</b>		0672 0	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Home</b>			Length of stay in lb		d. STREET ADDRESS (If outside, give location) <b>610 Davis</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Leo</b> Middle <b>Chandler</b> Last <b>Hale</b>				4. DATE OF DEATH Month <b>March</b> Day <b>20</b> Year <b>1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept 3, 1929</b>		9. AGE (In years last birthday) <b>27</b>	IF UNDER 1 YEAR OF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farm Laborer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>farm</b>	11. BIRTHPLACE (City and state or country) <b>East Prairie, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Leo Hale</b>				14. MOTHER'S MAIDEN NAME <b>Scena Lee Chandler</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>492-34-3658</b>		17. INFORMANT Address <b>Scena Lee Chandler Charleston, Mo</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>I Be</b>							INTERVAL BETWEEN ONSET AND DEATH <b>7 yrs</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____							PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a. m. _____ p. m. _____							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <b>3-16-57</b> to <b>3-20-57</b> and last saw <sup>her</sup> him alive on <b>3-20-57</b> Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <b>Donna Bernhardt</b> (Degree or title)				22b. ADDRESS <b>Charleston Mo</b>		22c. DATE SIGNED <b>3/21/57</b> (State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>3/22/57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Oak Grove</b>		23d. LOCATION (City, town, or county) <b>Charleston, Mo.</b> (State)		
24. FUNERAL DIRECTOR <b>Mc Mickle Charleston, Mo.</b> ADDRESS				25. DATE RECD. BY LOCAL REG. <b>3-21-57</b>		26. REGISTRAR'S SIGNATURE <b>Donathy B. Hathorn</b>	

(Licensed Embalmer's Statement on Reverse Side)

Health,  
& Welfare  
Public  
ServiceS. 300  
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Securing the medical certification in the specific manner required by 192.040, RSMo, is necessary to ensure the accuracy of the information reported on this certificate.

RECEIVED  
Miss. Co. Health  
County File No. \_\_\_\_\_  
Date Filed 3-2

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 \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Edgar W. Spille

Licensed Embalmer No. 469

P. O. Address Charlottesville

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 embalmed by a STUDENT; he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.