

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-015642

STATE FILE NUMBER
4049

FILED APR 18 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

4049

300
1-57
0

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS, MO.</u>		c. CITY OR TOWN <u>ST. LOUIS</u>	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. LOUIS CITY HOSP. #1</u>		d. STREET ADDRESS (If outside, give location) <u>239 2227 CALIFORNIA</u>	
Length of stay in lb		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HENRY</u> Middle Last <u>CHANDLER</u>			4. DATE OF DEATH Month <u>APRIL</u> Day <u>11</u> Year <u>1958</u>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT 6 1868</u>
9. AGE (In years last birthday) <u>89</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED INSPECTOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>EMERSON ELECTRIC</u>	11. BIRTHPLACE (City and state or country) <u>Mo.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13a. FATHER'S NAME <u>JOHN CHANDLER</u>	
13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		14. NAME OF HUSBAND OR WIFE <u>IDA CHANDLER (DEC'D)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Address <u>ZORA TEELING 2227 CALIFORNIA</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cortical Atrophy of Brain</u>			INTERVAL BETWEEN ONSET AND DEATH <u>NOT DEF. KNOWN</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Generalized Arteriosclerosis</u>			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>450.0</u>	
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 <u>8/20/58</u> to <u>4/11/58</u> and last saw her alive on <u>4/11/58</u> Death occurred at <u>8:05 A.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>John Doubek Jr. M.D.</u>		22b. ADDRESS <u>1515 L. FALETTE AVE.</u>	22c. DATE SIGNED <u>4/11/58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>APR 13 1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>DILLON CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>ST. JAMES Mo</u>
24. FUNERAL DIRECTOR ADDRESS <u>Thomas Lutes 2906 Francis</u>		25. DATE RECD. BY LOCAL REG. <u>APR 12 '58</u>	26. REGISTRAR'S SIGNATURE <u>J. Earl Smith, M.D.</u> S.P.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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.

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 *Armen C. Hill*
Licensed Embalmer No. *4347*
P. O. Address *2906 ...*

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.