

FEDERAL BUREAU OF INVESTIGATION
U.S. DEPARTMENT OF JUSTICE
FILED VS JUN 2 1960
REGISTRATION DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-018766

STATE FILE NUMBER

Registration District No. 77 Primary Registration District No. 2016 Registrar's No. 200

1. PLACE OF DEATH a. COUNTY <u>COLE</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>COLE</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>JEFFERSON CITY</u>		Length of stay in 1b <u>4 Days</u>		c. CITY OR TOWN <u>JEFFERSON CITY</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Memorial Community</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>722 LOCUST STREET</u>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Lois</u> Middle <u>MOCOLA</u> Last <u>CHANDLER</u>				4. DATE OF DEATH Month <u>MAY</u> Day <u>30</u> Year <u>1960</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>8-3-22</u>	9. AGE (last birthday) <u>37</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>OXFORD, N.C.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>THOMAS HICKS</u>			13b. MOTHER'S MAIDEN NAME <u>LAVINIA TABOER</u>		14. NAME OF HUSBAND OR WIFE <u>ANDREW CHANDLER</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>420-34-1995</u>	17. INFORMANT <u>ANDREW CHANDLER</u>		Address <u>722 LOCUST</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>Cardiac failure</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Diabetic Mellitus</u>							<u>5 years</u>
DUE TO (c) <u>Kimmelpeil Wilson Syndrome</u>							<u>5 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Hypertension, Glomerulonephritis</u>						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	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 _____ a.m. _____ p.m. _____		Month, Day, Year					
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>5/26/60</u> to <u>5/30/60</u> and last saw her ^{her} alive on <u>5/30/60</u> Death occurred at <u>7:30 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>N Kanagawa MD</u>				22b. ADDRESS <u>515 E High St</u>		22c. DATE SIGNED <u>5/30/60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal & Burial</u>		23b. DATE <u>2 June 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Harrisburg Cemetery</u>		23d. LOCATION (City, town, or county) <u>Oxford - N.C.</u>		
24. FUNERAL DIRECTOR <u>Dulle Funeral Home</u>			ADDRESS <u>Jeff City</u>	25. DATE RECD. BY LOCAL REG. <u>30 May 1960</u>	26. REGISTRAR'S SIGNATURE <u>R.P. Norris MD - Richter Dep.</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

0961 9 - NNC SA

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

James E. Edward

Licensed Embalmer No. 4978

P. O. Address Jeff City Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.