

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-041358

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 146

Primary Registration District No. 3026

Registrar's No. 579

FILED DEC 12 1961

1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Jackson									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Independence		Length of stay in 1b Life		c. CITY OR TOWN Independence		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Indep. Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 906 N. Lynn		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Middle Last MR. FRANK GREEN CHANDLER.				4. DATE OF DEATH Month Day Year December 2, 1961									
5. SEX Male		6. COLOR OR RACE White		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH Oct. 26, 1898		9. AGE (last birthday) 63		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Standard Oil Company				10b. KIND OF BUSINESS OR INDUSTRY Oil Company		11. BIRTHPLACE (City and state or country) Independence, Mo.		12. CITIZEN OF WHAT COUNTRY USA					
13a. FATHER'S NAME Willis Chandler				13b. MOTHER'S MAIDEN NAME Callie Easter				14. NAME OF HUSBAND OR WIFE Velma Chandler					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No						17. INFORMANT Address Mrs. Velma Chandler 906 N. Lynn, Indep., Mo.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Certainly acute Heart Disease with advanced cardiac decompensation</i> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH <i>Chronic</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Hypertension</i>							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 <i>Aug 31, 1957</i> to <i>Dec 2, 1961</i> and last saw her <i>him</i> alive on <i>Dec 1, 1961</i> Death occurred at <i>1:15 Am</i> on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <i>W. H. Hitterson M.D.</i>						22b. ADDRESS <i>604 W. Maple Independence, Mo</i>				22c. DATE SIGNED <i>12/2/61</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Dec. 4, 1961		23c. NAME OF CEMETERY OR CREMATORY Woodlawn		23d. LOCATION (City, town, or county) Independence, Missouri							
24. FUNERAL DIRECTOR ADDRESS OTT & MITCHELL, Indep., Mo.				25. DATE RECD. BY LOCAL REG. <i>12-4-61</i>		26. REGISTRAR'S SIGNATURE <i>Alba L. Craig</i>							

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DEC 13 1961

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 _____

Licensed Embalmer No. 3156

P. O. Address Indep Ho

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.