WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County: Cooper

Township: ____ or Village: ____ or City: Pilot Grove (NO. ____ St.: ____ Ward: ____)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

Registration District No. 323 File No. 33868

Primary Registration District No. 4135 Registered No. 13

FULL NAME Child Unnamed Chapman

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	white	single

DATE OF BIRTH: Oct (Month) 25 (Day), 1916 (Year)

AGE: — yrs. — mos. — ds. If LESS than 1 day, 14 hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): —

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BIRTHPLACE (City or town, State or foreign country): Pilot Grove Mo

PARENTS

NAME OF FATHER: E. E. Chapman

BIRTHPLACE OF FATHER (City or town, State or foreign country): Mechanicsburg Pa

MAIDEN NAME OF MOTHER: Mary J. Shaft

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Pilot Grove Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. E. Chapman

(ADDRESS) Pilot Grove Mo

Filed Oct 26, 1916 T. O. Pendleton REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Oct. (Month) 26 (Day), 1916 (Year)

I HEREBY CERTIFY, that I attended deceased from Oct 26, 1916, to Oct 26, 1916, that I last saw him alive on Oct 26, 1916, and that death occurred, on the date stated above, at 4 p.m.

The CAUSE OF DEATH* was as follows:

1a Atelectasis

1b

(Duration) — yrs. — mos. 14 hours ds.

Contributory (SECONDARY) ____ (Duration) ____ yrs. ____ mos. ____ ds.

(Signed) T. O. Pendleton M. D.

Oct 26, 1916 (Address) Pilot Grove

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted if not at place of death? ____

Former or usual residence ____

PLACE OF BURIAL OR REMOVAL: Pilot Grove

DATE OF BURIAL: Oct 26, 1916

UNDERTAKER: Elliott & Chapman

ADDRESS: Pilot Grove

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County.....

Township ..... Registration District No. ..... File No. .....
or
Village..... Primary Registration District No. ..... Registered No. .....
or
City ..... (NO. ..... , ... St.; ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME .....

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very import

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

..... , 1.....
(Month) (Day) (Year)

AGE

.....yrs. .....mos. .....ds.

If LESS than 1 day, ...hrs. or .....min.?

OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(ADDRESS) .....

Filed ..... , 191..... , ...
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

..... , 191.....
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from ..... , 191..... , to ..... , 191..... , that I last saw h..... alive on ..... , 191..... , and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

.....(Duration).....yrs. .....mos. .....ds.

Contributory .....
(SECONDARY)
.....(Duration).....yrs. .....mos. .....ds.

(Signed) ..... M. D.

..... , 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death.....yrs. .....mos. .....ds. In the State.....yrs. .....mos. .....ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
	..... , 191.....
UNDERTAKER	ADDRESS