FEB 23 1928

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

Do not use this space.

1985

1. PLACE OF DEATH
County Nodaway — Registration District No. 623 — File No.
Township Washington — Primary Registration District No. ~~4374~~ — Registered No. 1
City Guilford Mo. (No. 5825 St. Ward)

2. FULL NAME Robert Koch Chapman
(a) Residence. No. St. Ward. Evergreen Colorado
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred — yrs. 2 mos. — ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

5A. IF MARRIED, ~~WIDOWED, OR DIVORCED~~ HUSBAND OF ~~(OR) WIFE~~ OF Florence Chapman

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 6 - 1885

7. AGE: Years 43 — Months — Days 29 — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Accountant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Bedison
(STATE OR COUNTRY) Nodaway Co. Mo.

PARENTS
10. NAME OF FATHER William A. Chapman
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Knox Co. Ohio
12. MAIDEN NAME OF MOTHER Arnilda T. Tharp
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Newton
(STATE OR COUNTRY) Iowa.

14. INFORMANT W. A. Chapman
(Address) Maryville Mo.

15. FILED Jan. 6 1928 J. M. McClanahan REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 5 1928

17. I ~~HEREBY~~ CERTIFY, That I attended deceased from Nov 3rd, 1927 to Jan 5 1928 that I last saw him alive on Jan 5, 1928, and that death occurred, on the date stated above, at 10 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS: Pulmonary Tuberculosis

(duration) 16 yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? Do not know
DID AN OPERATION PRECEDE DEATH? No DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? State Board Test
(Signed) A. D. Barnett, M. D
1/5, 1928 (Address) A. D. Barnett

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Savannah — DATE OF BURIAL: Jan 8 1928

20. UNDERTAKER: J. Fred Urhund — ADDRESS: Savannah

42-0-29

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County: Midaway — Registration District No.: 623 — File No.:

Township: Washington — Primary Registration District No.: 5825 — Registered No.:

City: (No. St. Ward)

2. FULL NAME Robert Koch Chapman

(a) Residence. No. St., Ward. (If nonresident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
M.	W.	M.

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) X Dec 6 - 1885 X

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
X 42 -	X 0.	X 29	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY)

14. INFORMANT
(Address)

15. FILED 3 12, 19 28 J M McClanahan, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 5 19 28

17. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19..., that I last saw h... alive on ..., 19..., 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.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed), M. D
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
(	19

20. UNDERTAKER	ADDRESS
J. Fred Terhune	Savannah Mo.

SUPPLEMENTARY

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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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