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

Do not use this space.

17926

File No. .....

Registered No. .....

1. PLACE OF DEATH

County: Newton — Registration District No.: 614

Township: Neosho — Primary Registration District No.: 3001

City ..... (No. ....., ... St. ..... Ward)

2. FULL NAME: Edwin Clark 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: 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~~: Alma Chapman

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Oct 5 1858

7. AGE: Years 69 | Months 7 | Days 15 | If LESS than 1 day, ... hrs. or ..... min.

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

9. BIRTHPLACE (CITY OR TOWN): St Louis
(STATE OR COUNTRY): Missouri

PARENTS

10. NAME OF FATHER: E. A. Chapman

11. BIRTHPLACE OF FATHER (CITY OR TOWN): St Louis
(STATE OR COUNTRY): Missouri

12. MAIDEN NAME OF MOTHER: Catherine Parker

13. BIRTHPLACE OF MOTHER (CITY OR TOWN): St Louis
(STATE OR COUNTRY): Missouri

14. INFORMANT: Alma Chapman
(Address): Neosho Mo

15. FILED ....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): May 20 1928

17. I HEREBY CERTIFY, That I attended deceased from May 19 1928, 19..., to May 20, 19..., that I last saw h. ..... alive on May 19th 1928, 19..., and that death occurred, on the date stated above, at 11:45 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

93 Pericarditis and myocarditis
90 Bronchitis two weeks before
97 Compressor pneumonia and he had
Pericarditis (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY): Arteriosclerosis
Pyorrhoea (duration) long yrs. — mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED: Home
IF NOT AT PLACE OF DEATH: .....

DID AN OPERATION PRECEDE DEATH? No. DATE OF: .....

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? My experience

(Signed) M. L. Travis, M. D.

5/21, 1928 (Address) Neosho Mo

*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~~: Newtonia I.O.O.F.

DATE OF BURIAL: 5/21 1928

20. UNDERTAKER: Bingham's

ADDRESS: Neosho

...should be stated EXACTLY. PH... should state ...assified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Newton ..... Registration District No. 614 ..... File No. .....

Township Newtonia ..... Primary Registration District No. 5811 ..... Registered No. .....

City ..... (No. ....., ... St. ..... Ward)

2. FULL NAME Edwin Clark Chapman

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

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)

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.

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 5-21-, 1928 M T Pelus
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 20 1928

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

SUPPLEMENTARY

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

RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

S-17926