

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

Do not use this space.

24108  
3236

**1. PLACE OF DEATH**

County Jackson Registration District No. 399  
 Township Kaw Primary Registration District No. 100  
 City Kennett (No. 100) Hosp St.          Ward         

File No. 24108  
 Registered No. 3236

**2. FULL NAME** William C. Chapman

(a) Residence. No. Claycom Mo. St.          Ward.           
 (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 M 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 24 - 1888

7. AGE YEARS MONTHS Days If LESS than 1 day, hrs. or min.  
4 7 11 3         

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Bucklayer  
 (b) General nature of industry, business, or establishment in which employed (or employer)           
 (c) Name of employer         

9. BIRTHPLACE (CITY OR TOWN) Sweet Springs  
 (STATE OR COUNTRY) Mo.

10. NAME OF FATHER Allen P. Chapman

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Sci Sea  
 (STATE OR COUNTRY)         

12. MAIDEN NAME OF MOTHER Minnie Queen

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Wis  
 (STATE OR COUNTRY)         

14. INFORMANT Wiram J. Chapman  
 (Address) 327 So Monroe

15. FILED 7/30/28 M. M. Lesue  
Asst REGISTRAR

**2 MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 27 1928

17. I HEREBY CERTIFY, That I attended deceased from         , 1928, to         , 1928, that I last saw h.          alive on         , 1928, and that death occurred, on the date stated above, at          m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS  
Amnesia - stabil with paper

174  
 CONTRIBUTORY (SECONDARY) 198

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

19. DID AN OPERATION PRECEDE DEATH? Yes DATE July 27 1928  
 WAS THERE AN AUTOPSY? Yes  
 WHAT TEST CONTINUED DIAGNOSIS?           
 (Signed) Paul J. H. [unclear], M. D.  
7/27 1928 (Address) Deputy Coroner

\*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.

20. PLACE OF BURIAL, CREMATION, OR REMOVAL St. Monica DATE OF BURIAL July 30 1928

21. UNDERTAKER Boe & Henderson ADDRESS 158 Jack

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.

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**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.....  
Township.....  
City..... (No.....)..... St. .... Ward)

Registration District No. 399  
Primary Registration District No. 1002

File No.....  
Registered No. 3-2-36

2. FULL NAME.....

*William C 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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED S  
(write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 24 - 1880

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
3 11 3

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).....

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 7/30 19 25 M. M. Crowe REGISTRAR  
*Asst*

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 27 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.....

Every item of information should be care. A. SE OF DEATH in plain terms, so that it may be properly class. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-24108