

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

Do not use this space.

16288

2106

399

**1. PLACE OF DEATH**

County Jackson  
Township Franklin  
City Keokuk

Registration District No. 1002  
Primary Registration District No. 1002

File No. \_\_\_\_\_  
Registered No. \_\_\_\_\_  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Theo Chappel  
(a) Residence, No. 567 Troost ave Ward 1  
(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 <u>male</u>	4. COLOR OR RACE <u>col</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Single</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Unknown</u>		
7. AGE <u>23</u>	YEARS	MONTHS
		DAYS
	If LESS than 1 day, ..... hrs. or ..... min.	
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>Laborer</u> (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) <u>no</u>		
PARENTS	10. NAME OF FATHER <u>Frank Chappel</u>	
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <u>no</u>	
	12. MAIDEN NAME OF MOTHER <u>Mary Chappel</u>	
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <u>no</u>	
14. INFORMANT <u>Eda Miller</u> (Address) <u>567 Troost ave</u>		
15. FILED <u>5/24</u> , 19 <u>30</u> <u>M. M. Crowe</u> <u>act</u> REGISTRAR		

**MEDICAL CERTIFICATE OF DEATH**

3

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5-23 1930

17. I HEREBY CERTIFY, That I attended deceased from 5 12 1930, to 5-23 1930 that I last saw him alive on 5-23 1930 and that death occurred, on the date stated above, at 2:22 A m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Septicemia Pyemia  
93A  
115B  
36 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Septic Stomatitis  
Acute Myocarditis (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED Unknown  
IF NOT AT PLACE OF DEATH \_\_\_\_\_  
DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_  
WAS THERE AN AUTOPSY? no  
WHAT TEST CONFIRMED DIAGNOSIS? clinical  
(Signed) J. M. [Signature] M. D.

\*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 <u>Blue Ridge Town</u>	DATE OF BURIAL <u>5726</u> 19 <u>30</u>
20. UNDERTAKER <u>W. B. Moore</u>	ADDRESS <u>1820 E 18th</u>

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.

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

