

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

Do not use this space.

18601

1. PLACE OF DEATH
 66 County McDonald Registration District No. 518
 Township Anderson Primary Registration District No. 5688
 City _____ (No. _____) St. _____ (Ward _____)

2. FULL NAME William Madison 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 (write the word) Married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mayme F Chapman
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 15-1879
 7. AGE YEARS 51 MONTHS 11 DAYS 2 If LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Farmer!
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

FATHER 13. NAME James R Chapman

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

MOTHER 15. MAIDEN NAME Margaret E Lemon

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

17. INFORMANT Mrs Mayme Chapman
 (ADDRESS) Anderson, Mo

18. BURIAL, CREMATION, OR REMOVAL
 PLACE Anderson, Mo DATE 5/18 1931

19. UNDERTAKER Geo Fatus
 (ADDRESS) Anderson, Mo

20. FILED 5/18 1931 Andrew Mitchell
 Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 17 1931
 22. I HEREBY CERTIFY, That I attended deceased from Feb 15 1931 to May 17 1931
 I last saw h. alive on May 12 1931 Death is said to have occurred on the date stated above, at 11:45 pm.

The principal cause of death and related causes of importance were as follows:
Chronic Intestinal Toxemia Date of onset 1205
Influenza 1919
 Other contributory causes of importance _____
 Name of operation _____ Date of _____
 What test confirmed diagnosis? none Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____ 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place. _____
 Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? no
 If so, specify _____
 (Signed) S B Karch M. D.
 (Address) Anderson, Mo

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.

