

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

Do not use this space.

17851

1. PLACE OF DEATH

County..... Registration District No.....
Township..... Primary Registration District No.....
City *St. Louis* (No. *Wesconess Hospital*)

File No.....
Registered No. *4805*
St..... Ward.....

2. FULL NAME

(a) Residence, No. *4902 Ogyle Ave.* St. *12* Ward.

(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 <i>Male</i>	4. COLOR OR RACE <i>White</i>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <i>Married</i>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <i>Mary L Chapman</i>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <i>Oct 9, 1868</i>		
7. AGE	YEARS <i>63</i>	MONTHS <i>7</i>
	DAYS <i>6</i>	if LESS than 1 day, hrs. or min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <i>Retired</i>	
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. <i>Broker</i>	
	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) <i>Lexington, Nev.</i>		
MOTHER	13. NAME <i>Moses Chapman</i>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Unknown</i>	
	15. MAIDEN NAME <i>Laura Waddell</i>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Unknown</i>	
17. INFORMANT (ADDRESS) <i>J. L. Kattelle Dallas, Texas</i>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <i>Bellefontaine</i> DATE <i>May 17, 1937</i>		
19. UNDERTAKER (ADDRESS) <i>Wagoner 360 Olive St</i>		
20. FILED <i>MAY 17 1937</i> Registrar		

2 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *May 15, 1937*

22. I HEREBY CERTIFY, That I attended deceased from *May 14th, 1937, to May 15, 1937*
I last saw him alive on *6 P.M. of May 14, 1937*. Death is said to have occurred on the date stated above, at *6:45 P.M.*
The principal cause of death and related causes of importance were as follows:
Cerebral Hemorrhage
82A
97
Other contributory causes of importance:
Arterial Sclerosis - Indefinite
Date of onset *May 14*

Name of operation *None* Date of *None*
What test confirmed diagnosis? *Lab. Ex.* 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 *None*, 19...
Where did injury occur? *None*
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place. *None*

Manner of injury.....
Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....
If so, specify *No*
(Signed) *B. Schiller*, M. D.
(Address) *945 Mo Bldg. Jop.*

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.

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