

REC'D FEB 10 1939

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS 791  
CERTIFICATE OF DEATH700  
Do not use this space.

1. PLACE OF DEATH 4236 ENNIGHT

(a) County ..... Registration District No. 1008

(b) Township ..... Primary Registration District No. Registered No. 700

(c) City ST LOUIS, MO. (d) Street No. 4236 Ennigh Ave. St.  
(If death occurred in Hospital or Institution, write its name instead of street and number)

(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME DR. ALLEN CHAPMAN

(a) Residence, No. 4421 N. MARKET St. (If nonresident, give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX MALE 4. COLOR OR RACE COLORED 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) MARRIED

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) APRIL 28 1869

7. AGE YEARS 69 MONTHS 8 DAYS If LESS than 1 day, ..... hrs. or ..... min. 21\*

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. DENTIST

9. Industry or business in which work was done, as 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) LEXINGTON (STATE OR COUNTRY) VA.

13. NAME CHARLES CHAPMAN

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

15. MAIDEN NAME UNKNOWN

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

17. INFORMANT ADA CHAPMAN (ADDRESS) 4421 N. MARKET

18. BURIAL, CREMATION, OR REMOVAL PLACE GREENWOOD DATE 1-23 39

19. FUNERAL DIRECTOR (NAME) F. L. GARNER (ADDRESS) 2829 WASHINGTON

20. FILED JAN 23 1939 Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4/19/39 19

22. I HEREBY CERTIFY, That I attended deceased from 19....., to 19....., 19.....

I last saw h..... alive on..... 19..... Death is said to have occurred on the date stated above, at 5:51 P.M.

The principal cause of death and related causes of importance were as follows:

Coronary Occlusion  
Arterio Sclerosis  
Other contributory causes of importance: AF

Name of operation ..... Date of.....

What test confirmed diagnosis? ..... 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) Fred Perry, M.D.

- (Address) 1008 Ennigh Ave.

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.

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, .....

....., or by .....

Registered Apprentice No. ...., working under my personal supervision.

Signed

*Arthur L. Heilicard*

Licensed Embalmer No. *3389*

P. O. Address *3028 Dickson S*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**