

REC JUN 19 1939

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

18891
Do not use this space.

1. PLACE OF DEATH

(a) County Jasper Registration District No. 408
 (b) Township _____ Primary Registration District No. 3020 Registered No. 78
 (c) City Carthage, Mo. (d) Street No. McCune-Brooks Hospital 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. da. (f) How long in U.S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME Cora Isabell Chapman

(a) Residence, No. Reeds, Route #1 St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Daniel A. Chapman
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan. 30, 1878
 7. AGE YEARS 61 MONTHS 3 DAYS 0 If LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife
 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) Aurora 0
 (STATE OR COUNTRY) Missouri 1

FATHER 13. NAME John S. Wheat
 14. BIRTHPLACE (CITY OR TOWN) Jefferson County
 (STATE OR COUNTRY) Indiana

MOTHER 15. MAIDEN NAME Malissie C. Brashear
 16. BIRTHPLACE (CITY OR TOWN) Chesapeak
 (STATE OR COUNTRY) Missouri

17. INFORMANT Mr. Dan Chapman
 (ADDRESS) Reeds, Route #1

18. BURIAL, CREMATION, OR REMOVAL
 PLACE New Hope Cemetery Date 5-3-39

19. FUNERAL DIRECTOR (NAME) Ulmer
 (ADDRESS) Carthage, Mo.

20. FILED May 2, 1939 E. J. McEntire M.D.
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 30, 1939

22. I HEREBY CERTIFY, That I attended deceased from Apr 28, 1939, to April 30, 1939
 I last saw her alive on Apr 29, 1939. Death is said to have occurred on the date stated above, at 8:10a.m.
 The principal cause of death and related causes of importance were as follows:

✓ Date of onset Apr 25
Acute intestinal obstruction
 Other contributory causes of importance: -

Name of operation _____ Date of _____
 What test confirmed diagnosis? Clinical 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 Homer E. Durd M. D.
 (Signed) Carthage Mo
 (Address) _____

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.

1226

RECEIVED
DISTRICT HEALTH OFFICER NO. 6
DISTRICT FILE NUMBER
DATE FILED

RECEIVED

District Health Officer No. 6,

District File Number 6-6-39-1246

Date Filed 6-8-39

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

E. L. ...

Licensed Embalmer No. 2722

P. O. Address Carthage

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.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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1. PLACE OF DEATH

(a) County Jasper Registration District No. 408
(b) Township Primary Registration District No. 3020 Registered No.
(c) City Carthage (d) Street No.
(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

Cora Isabell Chapman
(a) Residence, No. St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) M

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
61 3 0

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
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) (STATE OR COUNTRY)

FATHER 13. NAME

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

MOTHER 15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE 19.....

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 19.....

Local Registrar.

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4-30 1951

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

I last saw h..... alive on, 19..... Death is said to have occurred on the date stated above, at..... m.

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

acute intestinal obstruction
strangled hernia
Date of onset

Other contributory causes of importance:

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

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?

If so, specify

(Signed) Homer E. Boyd, M. D.

(Address) Carthage, Mo.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW. CAUSE OF DEATH IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important.

SUPPLEMENTARY

