

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

2147  
 Do not use this space.

1. PLACE OF DEATH  
 (a) County Cole Registration District No. 213  
 (b) Township Jefferson Primary Registration District No. 3014  
 (c) City Jefferson City, Mo. (d) Street No. 431 Adams 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 FRANCES ANN CHAPPEL  
 (a) Residence, No. 431 Adams 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 Negro 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Child

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 8-1-39

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ..... hrs. or ..... min.
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<u>5</u>	<u>13</u>	

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. Child  
 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) Jefferson City, Mo.

FATHER  
 13. NAME ~~Francis Ann Chappel~~  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) ~~Jefferson City, Mo.~~

MOTHER  
 15. MAIDEN NAME Annell Chappel  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Jefferson City, Mo.

17. INFORMANT Annell Chappel  
 (ADDRESS) 431 Adams

18. BURIAL, CREMATION, OR REMOVAL  
 PLACE City Cemetery DATE 1-14 1940

19. FUNERAL DIRECTOR (NAME) Tammeservice  
 (ADDRESS) Jeff. City Mo. !!!

20. FILED 1/15/40 Chapman Local Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 13 1939

22. I HEREBY CERTIFY, That I attended deceased from Jan 5 1939 to Jan 6 1939, 1939  
 I last saw her alive on Jan 6 1939. Death is said to have occurred on the date stated above, at 1:30 p.m.  
 The principal cause of death and related causes of importance were as follows:  
Bronchitis Pneumonia  
 Date of onset Jan 8, 1939  
107W

Other contributory causes of importance:  
none

Name of operation none 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? no 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) Gas R. Hill, M. D.  
 (Address) Jeff. City, Mo.

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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**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.....

Licensed Embalmer No.....

P. O. Address.....

**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.**