

FILED OCT 23 1940

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH32915  
Do not use this space.

1. PLACE OF DEATH Putnam 20  
(a) County ..... Registration District No. 724  
(b) Township York Primary Registration District No. 5955  
(c) or Powersville, Mo. (d) Street No. .... 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 Hugh Ulrick Chapman.  
(a) Residence, No. Putnam Co. Mo. Rental (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 Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Apr. 12, 1920

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
20 5 15

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. none  
9. Industry or business in which work was done, as saw mill, bank, etc. none  
10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) Flat Top, Colo. 1  
(STATE OR COUNTRY)

FATHER 13. NAME Ulrick Earl Chapman, 1  
(STATE OR COUNTRY)

14. BIRTHPLACE (CITY OR TOWN) Sewal, Iowa. 1  
(STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME Janie Reed

16. BIRTHPLACE (CITY OR TOWN) Logan, Kan.  
(STATE OR COUNTRY)

17. INFORMANT Mrs. Earl Chapman,  
(ADDRESS) Powersville, Mo.

18. BURIAL, CREMATION, OR REMOVAL Powersville Cem. DATE Sept. 27, 1940  
PLACE

19. FUNERAL DIRECTOR (NAME) Beary-Statton Co.,  
(ADDRESS) Powersville Mo.

20. FILED Sept 30 1940 Mrs. D. W. Pollock  
Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept. 27 1940

22. I HEREBY CERTIFY, That I attended deceased from Sept. 27 1940 to Sept. 27 1940

I last saw him alive on Sept. 27 1940. Death is said to have occurred on the date stated above, at 12:15 p.m.  
The principal cause of death and related causes of importance were as follows:

Convulsions and  
Contracture of throat  
muscles. I  
malnutrition

Date of onset

Other contributory causes of importance:

Spinal meningitis  
at 18 months.

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) L. V. McDonald, M.D.  
(Address) Powersville, Mo.

(Licensed Embalmer's Statement on Reverse Side)

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.

7913

RECEIVED

RECEIVED Health Officer No. 10  
District Health Officer No. 10

District File Number 10-40-1857

Date Filed OCT-8-1940

**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.

0  
10-11-40

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **32915-**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. **724**

Primary Registration District No. **5955-**

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County **Putnam**  
(b) City or town **York**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community \_\_\_\_\_ (Specify whether  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME

**Hugh Wilrick Chapman**

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex **m** 5. Color or race **w** 6. (a) Single, widowed, married, divorced **8**

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ years

7. Birth date of deceased: (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
**20 5 15** hr. min.

9. Birthplace: (City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace: (City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace: (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof: (Month) (Day) (Year)  
(Burial, cremation, or removal)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

20. MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept** day **7**  
year **1906** hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death: **Convulsion and contraction of throat muscle**  
Due to **malnutrition**

Due to **Epidemic**

Other conditions: **Spinal meningitis at 18 months**  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_

Of operations: \_\_\_\_\_

Of autopsy: **87B**

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)  
Means of injury \_\_\_\_\_

23. Signature **L. W. McDonald** (M.D. or other) \_\_\_\_\_

Address **Powersville** Date signed \_\_\_\_\_

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENT

