No. 2
-5-42

FILED AUG 13 1943

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 25553

Registration District No. 227 Primary Registration District No. 5804 Registrar's No.

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

1. PLACE OF DEATH:

(a) County MONROE

(b) City or town RURAL- JACKSON
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 4½ MI/S.E. OF PARIS
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether
In this community 47-3-5
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County MONROE 69

(c) City or town RURAL
(If outside city or town limits, write "RURAL")

(d) Street No. 4½ MI S.E. OF PARIS
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country ✓

3. (a) PRINT FULL NAME THOMAS F. CHAPMAN

3. (b) If veteran, name war ~~WAR WITH GERMANY~~

3. (c) Social Security No. 486-18-7572

4. Sex MALE

5. Color or race WHITE

6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife MARY CHAPMAN

6. (c) Age of husband or wife if alive 46 years

7. Birth date of deceased APRIL (Month) 24 (Day) 1896 (Year)

8. AGE: Years 47 Months 3 Days 5 If less than one day ..... hr. ..... min.

9. Birthplace MONROE CO, (City, town, or county) MO. 0 (State or foreign country)

10. Usual occupation FARMER

11. Industry or business

FATHER
12. Name OSCAR CHAPMAN
13. Birthplace SHELBY CO, (City, town, or county) MO. 0 (State or foreign country)

MOTHER
14. Maiden name MARY E. McGEE
15. Birthplace MONROE CO, (City, town, or county) MO. 0 (State or foreign country)

16. (a) Informant Mary Chapman
(b) Address PARIS, MO.

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 7-31-43 (Month) (Day) (Year)
(c) Place: burial or cremation PLEASANT HILL

18. (a) Signature of funeral director Speed & Blakey
(b) Address PARIS, MO

19. (a) 7-30-43 (Date received local registrar) (b) ..... (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JULY day 29
year 1943 hour 3 minute 50 P. M.

21. I hereby certify that I attended the deceased from 6-9-43, 19..., to 7-29, 1943
that I last saw him alive on 7-29-, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Hemostatic pneumonia — Duration NK

Due to cardiac failure myocarditis

Due to

Other conditions (Include pregnancy within 3 months of death) 13 p.

Major findings:
Of operations ✓
Of autopsy ✓

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?
(Specify type of place)
While at work? (e) Means of injury ✓

23. Signature Nellie G. Christman (~~M. Dean other~~) D.O.
Address PARIS, MO Date signed 7-30-43.

1274

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 8-43-1395
Date Filed AUG 11 1943

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 A. G. Blakey

Licensed Embalmer No. 2614

P. O. Address Paris, Mo.

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, fact should be so stated above.

. No. 2B
M—5-43
I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. aug.

Registration District No. 227 Primary Registration District No. ..... Registrar's No. .....

1. PLACE OF DEATH:

(a) County Monroe

(b) City or town Jackson A
(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 ..... 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) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3. (a) PRINT FULL NAME Thomas F 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 M

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 47 | Months 3 | Days 5 | If less than one day ..... hr. ..... min.

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

10. Usual occupation .....

11. Industry or business .....

FATHER
12. Name .....
13. Birthplace ..... (City, town, or county) ..... (State or foreign country)

MOTHER
14. Maiden name .....
15. Birthplace ..... (City, town, or county) ..... (State or foreign country)

16. (a) Informant .....
(b) Address .....

17. (a) ..... (Burial, cremation, or removal) (b) Date thereof ..... (Month) (Day) (Year)
(c) Place: burial or cremation .....

18. (a) Signature of funeral director .....
(b) Address .....

19. (a) 8-2-43 (Date received local registrar) (b) Maynie Gaston (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month July day 29 year 1943 hour 3 minute 30 P M.

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

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions ..... (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

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? ..... (Specify type of place)

While at work? ..... (e) Means of injury .....

23. Signature ..... (M. D. or other) .....

Address ..... Date signed .....

SUPPLEMENTARY

5-25553