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FILED JUN 9 3 18  
Registration District No. 1344

Primary Registration District No. 1003

Registrar's No. 5074

1. PLACE OF DEATH:

(a) County St. Louis, Missouri  
(b) City or town St. Louis, Missouri  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Homer G. Phillips Hospital 0  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 19 days  
(Specify whether  
In this community 50 years  
years, months or days)

3. (a) PRINT FULL NAME Katie Chappell  
3. (b) If veteran, name war None  
3. (c) Social Security No. None

4. Sex Female 5. Color or race Colored  
6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Walter H. Chappell  
6. (c) Age of husband or wife if alive 56 yrs. years  
7. Birth date of deceased April 11 1873  
(Month) (Day) (Year)

8. AGE: Years 71 Months I Days 20 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business None

MOTHER FATHER { 12. Name Charlotte Buckner  
13. Birthplace Frankfort, Ky. (City, town, or county) (State or foreign country)  
14. Maiden name William H. Buckner  
15. Birthplace Frankfort Ky. (City, town, or county) (State or foreign country)

16. (a) Informant Walter H. Chappell

(b) Address 3102 Lucas Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof June 5, 1944  
(Month) (Day) (Year)

(c) Place: burial or cremation Friedens Evangelical Cem.

18. (a) Signature of funeral director C. J. Nash

(b) Address 3847 Pag Blvd.

19. (a) JUN 2 1944 (Date received local registrar) (b) J. Z. Bredenkamp (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

Missouri 000  
17  
(a) State Missouri (b) County  
(c) City or town St. Louis, 9  
(If outside city or town limits, write "RURAL") 21  
(d) Street No. 3102 Lucas  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country No 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 31,  
year 1944 hour 8 minute 20 A. M.

21. I hereby certify that I attended the deceased from May 12, 1944 to May 31, 1944  
that I last saw her alive on May 31, 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death: Hypertensive Cardio Vascular Disease Unk.  
Duration

Due to  
Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

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 Alva Moore (M. D. or other)

Address 2601 Whittier Date signed 5/31/44

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

**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

*3847 Fay Paul*

Registered Apprentice No.

working under my personal supervision.

Signed

*C. J. Nash*

Licensed Embalmer No.

*2432*

P. O. Address

*3847 Fay*

**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.**