

FILED FEB 16 1945

Registration District No. 120

Primary Registration District No. 5450

Registrar's No. 8

1. PLACE OF DEATH:

(a) County Sentry
(b) City or town Rural Miller Twp
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community Lifelong years, months or days

3. (a) PRINT FULL NAME Norissa Belle Chapman
(b) If veteran, name war _____ (c) Social Security No. _____

4. Sex F 1. Color or race _____ 2. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife W Chapman 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased: Aug 21 1868
(Month) (Day) (Year)

8. AGE: Years 76 Months 5 Days X If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

MOTHER FATHER { 11. Industry or business _____

12. Name Thomas Allen
13. Birthplace Ohio
(City, town, or county) (State or foreign country)
14. Maiden name Louisa Gray
15. Birthplace Ohio
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Abe Burton
(b) Address M^c Fall Mo R
17. (a) Burial (b) Date thereof 1-24-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Gate Ridge
18. (a) Signature of funeral director Edstrom
(b) Address Patterson Mo
19. (a) Jan 26 1945 (b) Alfred H Miller
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Sentry
(c) City or town Rural Miller Twp 58
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 21
year 1945 hour 8 minute _____ A. M.

21. I hereby certify that I attended the deceased from Jan 13, 1945, to Jan 19, 1945,
that I last saw her alive on Jan 18, 1945,
and that death occurred on the date and hour stated above.

Immediate cause of death Acute myocarditis 2 who
Duration _____

Due to _____

Due to _____

Other conditions: _____
(Include pregnancy within 3 months of death)

Major findings: 930
Of operations _____
Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged etiologically.

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 C. J. Pray (M. D. or other) _____
Address Albany Mo Date signed 1-26-45

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

Handwritten initials

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 *G. S. Brown*

Licensed Embalmer No. *2887*

P. O. Address *Pattersonburg, Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. March
Registrar's No. 8

Registration District No. 120

Primary Registration District No. 5450

1. PLACE OF DEATH:

(a) County Hentry
(b) City or town Rural Miller Jung
(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

3. (a) PRINT FULL NAME Noussia B. Chapman

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race White 6. (a) Single, widowed, married, divorced N

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Aug 21
(Month) (Day) (Year)

8. AGE: Years 76 Months 5 Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER {
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 _____

Address _____
19. July 21-1944 (b) Stover W. M. Motes
(Date received local registrar) (Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ day _____
year 1944 hour _____ minute _____ M.

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

Immediate cause of death _____
Duration _____

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

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

Address _____ Date signed _____

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

SUPPLEMENTARY

0092