

Registration District No. 377

Primary Registration District No. 6076

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Manchester
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Manchester Nursing Home
(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)

3. (a) PRINT FULL NAME Mabel Chapman
(b) If veteran, name war Nil
(c) Social Security No. None

4. Sex Female / 5. Color or race White
6. (a) Single, widowed, married, divorced Widow
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased April 11 1872
(Month) (Day) (Year)

8. AGE: Years 72 Months 11 Days 29
If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER

12. Name H.L. Harrington
13. Birthplace St. Johnsbury Vermont
(City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Joseph Chapman
(b) Address DeKalb, Ill.

17. (a) Removal (b) Date thereof 4-11-45
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Monmouth, Illinois

18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Blvd

19. (a) APR 11 1945 (b) C. J. McKarran
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town Kirkwood
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? 1 (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 10
year 1945 hour 11 minute 20 A.M.
21. I hereby certify that I attended the deceased from Dec 1,
1943, to April 10, 1945.
that I last saw her alive on April 9, 1945.
and that death occurred on the date and hour stated above.

Immediate cause of death Diabetes mellitus
chronic myocarditis
senility
Due to _____
Due to 61

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 A. L. Wierlein M.D. (M. D. or Doctor)
Address 3507 Poloma Date signed 4-10-45

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

MAY 28 1945
MAY 28 1945

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 *Albert L. Haffes*.....

Licensed Embalmer No. *5971*.....

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, fact should be so stated above.