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THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

16209

State File No. _____

FILED JUN 14 1945

Primary Registration District No. 5055

Registrar's No. 44

1. PLACE OF DEATH:

(a) County Barry

(b) City or town Peerce City, Mo. Rural
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Canna Creek Hwy
(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 Nancy Chapman

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

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife Widowed

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

7. Birth date of deceased MAY 13 1853
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

92 5 _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER

12. Name Nancy Insler

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

14. Maiden name George Insler

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

16. (a) Informant Thrs Chapman

(b) Address Peerce City

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof May 20 1945
(Month) (Day) (Year)

(c) Place: burial or cremation Bethel - (gally)

18. (a) Signature of funeral director Wilbur Bond

(b) Address Peerce City, Mo.

19. (a) May 18 1945 (Date received local registrar) (b) Charles J. Hoou (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Barry

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

(d) Street No. South of Peerce City
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 18
year 1945 hour 10:50 PM minute _____ M.

21. I hereby certify that I attended the deceased from Apr 1945 to May 18 1945
that I last saw her alive on May 17 1945
and that death occurred on the date and hour stated above.

Immediate cause of death arteric stenosis

Duration unknown

Due to _____

Due to _____

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

Major findings: 92a

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) Address of injury _____

23. Signature Charles J. Hoou (M. D. or other) 100

Address Peerce City Date signed 5/19/45

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

RECEIVED

District Health Officer No. 6;

District File Number 645-716

Date Filed JUN 12 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 J. E. Culver

Licensed Embalmer No. 3584

P. O. Address Cassville 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. June
Registrar's No. 46Registration District No. 43Primary Registration District No. 5055

1. PLACE OF DEATH:

- (a) County Barry
 (b) City or town Rural Barry
(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 years, months or days)

3. (a) PRINT FULL NAME Nancy Chapman

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

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

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

7. Birth date of deceased May 13
(Month) (Day) (Year)8. AGE: Years 92 Months _____ Days _____
If less than one day _____ min.9. Birthplace unknown
(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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) Audna Willoughby
(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 May day _____
year 1945 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 _____

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 _____ (M. D. or other) _____
Address _____ Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY

16209