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

FILED JAN 25 1946

State File No. 1998

Registration District No. 4031 20

Primary Registration District No. 20 4031

Registrar's No. 17

1. PLACE OF DEATH:

(a) County Bates

(b) City or town Adrian
(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 80 Years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Bates 7

(c) City or town Adrian 0
(If outside city or town limits, write "RURAL")

(d) Street No. 0
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Frank Chapman

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male 0

5. Color or race White

6. (a) Single, widowed, married, divorced Married /

6. (b) Name of husband or wife Lucinda

6. (c) Age of husband or wife if alive 76 years

7. Birth date of deceased July (Month) 6 (Day) 1859 (Year)

8. AGE: Years 86 Months 6 Days 6 If less than one day ..... hr. ..... min.

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

10. Usual occupation Retired Farmer

11. Industry or business

FATHER
12. Name George Chapman
13. Birthplace Unknown (City, town, or county) 9 (State or foreign country)

MOTHER
14. Maiden name Winnie Keene
15. Birthplace Unknown (City, town, or county) 9 (State or foreign country)

16. (a) Informant Henry Chapman /
(b) Address Adrian Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-15-46 (Month) (Day) (Year)
(c) Place: burial or cremation Crescent Hill Cem.

18. (a) Signature of funeral director Creath & Six
(b) Address Adrian Mo

19. (a) Jan 14-1946 (Date received local registrar) (b) Myra Owens (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 12 year 1946 hour 3 minute 15 A.M.

21. I hereby certify that I attended the deceased from Dec. 2 1945, to Jan. 11, 1946 that I last saw him alive on Jan. 11, 1946 and that death occurred on the date and hour stated above.

Immediate cause of death Nephritis

Due to Arterial sclerosis

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Duration

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 E. E. Robinson (M. D. ~~or other~~)

Address Adrian, Mo. Date signed 1-14-46

16

(Licensed Embalmer's Statement on Reverse Side)

JAN 29 1946

12-45-1383

1-21-46

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

& Fred T. Creath #3343, Registered Apprentice No.

working under my personal supervision.

Signed

Licensed Embalmer No. 3650

P. O. Address: Adrian Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w 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 CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 7 et

Registration District No. 20 Primary Registration District No. 40 31 Registrar's No. 17

1. PLACE OF DEATH:

(a) County Bates

(b) City or town Adrian
(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)

In this community

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 Frank 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 July (Month) 6 (Day) (Year)

8. AGE: Years 86 Months 6 Days If less than one day hr. min.

9. Birthplace (City, town, or county) Ohio (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) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January 2 year 1946 hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19;

that I last saw him alive on 19;

and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Nephritis

Due to Arteriosclerosis

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

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 E. E. Robinson (M. D. or ~~other~~)

Address Adrian, Mo. Date signed 1-29-46

SUPPLEMENTARY

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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

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