FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED FEB 25 1949

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 4031

Registration District No. 37 — Primary Registration District No. 4049 — Registrar's No. 5

1. PLACE OF DEATH:
(a) County Boone
(b) City or town Centralia Mo
(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 ..... years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Boone (b) County Mo 10
(c) City or town Centralia Mo
(If outside city or town limits, write "RURAL")
(d) Street No. South Lease Ave.
(If rural, give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country —

3. (a) PRINT FULL NAME MARY CHAPPLE
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 Married
6. (b) Name of husband or wife James S Chapple
6. (c) Age of husband or wife if alive ✓ years
7. Birth date of deceased MAY 14 (Month) 1868 (Day) (Year)

8. AGE: Years 80 Months 8 Days 25 If less than one day ..... hr. ..... min.

9. Birthplace St Louis Co (City, town or county) MO (State or foreign country) 11

10. Usual occupation —

11. Industry or business

FATHER
12. Name William Gilmore
13. Birthplace Iowa (City, town or county) (State or foreign country)

MOTHER
14. Maiden name Malissa Vance
15. Birthplace Ill (City, town or county) (State or foreign country)

16. (a) Informant Mr James Chapple
(b) Address Centralia Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 10-1949 (Month) (Day) (Year)
(c) Place: burial ~~or cremation~~ Holladay Mo
18. (a) Signature of funeral director Gene Jennings
(b) Address Centralia Mo
19. (a) Feb 19-1949 (Date received local registrar) (b) Maud McBride (Registrar's signature) 30

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month FEB day 9
year 1949 hour 7 minute 30 A.M.

21. I hereby certify that I attended the deceased from 2-1 1949 to 2-9 1949; that I last saw her alive on 2-9 1949; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Coronary Thrombosis	2 hrs.
Hypertensive Heart Disease	9 yrs.
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN
Underline the cause of 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 R. P. Robert ~~(M. D. or other)~~ DO
Address Centralia, Mo Date signed 2-10-49

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed FEB 24 1949

MAR 11 1949

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 Gerry Jernigan

Licensed Embalmer No. 4270

P. O. Address Centralia, 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.