

FILED AUG 12 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **22416**  
Registrar's No. **230**

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

BIRTH NO. _____		REG. DIST. NO. <u>1</u>		PRIMARY REG. DIST. NO. <u>3000</u>		Registrar's No. <u>230</u>	
1. PLACE OF DEATH a. COUNTY <u>Adair</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Sullivan</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kirksville</u>		c. LENGTH OF STAY (In this place) <u>1 da</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Green City</u>		/ 05 0 0 1	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Stickler Hospital</u>				d. STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED (Type or Print) <u>John Hayden Chapman</u>			a. (First) _____ b. (Middle) _____ c. (Last) _____			4. DATE OF DEATH (Month) (Day) (Year) <u>Aug 5, 1949</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Nov 28, 1876</u>	
9. AGE (In years last birthday) <u>72</u>		IF UNDER 1 YEAR Months <u>8</u> Days <u>9</u>		IF UNDER 12 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Insurance Agent</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Insurance</u>		11. BIRTHPLACE (State or foreign country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>Thomas Jefferson Chapman</u>			13b. MOTHER'S MAIDEN NAME <u>Mary Shepherd</u>			14. NAME OF HUSBAND OR WIFE <u>Nettie Chapman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>495-30-2799</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Nettie E. Chapman</u>		ADDRESS <u>Green City, Mo</u>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  <i>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Shock; due to fracture right femur,</u> <u>surgical neck</u> ANTECEDENT CAUSES <u>Cardiac dyscompensation</u> DUE TO (b) <u>Nephritis, chronic</u> DUE TO (c) <u></u> II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>				INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>6 months</u> <u>10 years</u> <u>6 9/10</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>Accident</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Green City, Sullivan Mo.</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>8-4-49</u>		21e. INJURY OCCURRED WHILE AT WORK? <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Fell</u>		105	
22. I hereby certify that I attended the deceased from <u>May 1945</u> , to <u>Aug. 5, 1949</u> , that I last saw the deceased alive on <u>Aug. 5, 1949</u> , and that death occurred at <u>5:00 A.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>R. Stickler</u>				23b. ADDRESS <u>Kirksville, Missouri</u>		23c. DATE SIGNED <u>8-5-49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Aug 7, 1949</u>		24b. DATE <u>Aug 7, 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Mt Olivet Cemetery</u>		24d. LOCATION (City; town, or county) (State) <u>Green City, Mo</u>	
DATE REC'D BY LOCAL REG. <u>Aug 5-49</u>		REGISTRAR'S SIGNATURE <u>Kato Lambert</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Henry E. Keel</u>		ADDRESS <u>508 Green City</u>	

APR 4 1950

AUG 31 1949

APR 24 1950

RECEIVED AUG 10 1949  
District Health Officer N  
District File Number 8-69  
Date Filed AUG 10 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

Student Embalmer No.

working under my personal supervision.

Signed

Archie W. Wade

Signed.....

Student Embalmer

Licensed Embalmer No.

3037

P. O. Address

Green City

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.