

S. No. 300
V. 10-48

FILED JAN 8 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

43391

6225 State File No. ~~3076~~ Registrar's No. 195 (135)

BIRTH NO. _____ REG. DIST. NO. 360 PRIMARY REG. DIST. NO. ~~3076~~ Registrar's No. 195 (135)

1080
2

1. PLACE OF DEATH a. COUNTY <u>Vernon</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u>	
b. CITY OR TOWN <u>Rural - Washington</u> c. LENGTH OF STAY (in this place) <u>25 yrs 11 mos</u>		c. CITY OR TOWN <u>Aurora</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>State Hospital #3</u>		d. STREET ADDRESS (If rural, give location)	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Rose</u> b. (Middle) <u>-</u> c. (Last) <u>Chapman</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Dec. 24 - 1950</u>
---	--

5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Apr. 1 - 1886</u>	9. AGE (in years last birthday) <u>64</u>	IF UNDER 1 YEAR Months <u>3</u> Days <u>24</u>	IF UNDER 24 HRS. Hours <u>-</u> Min. <u>-</u>
----------------------	-------------------------------	---	---------------------------------------	---	--	---

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	11. BIRTHPLACE (State or foreign country) <u>Mount Vernon, Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
--	--	---	--

13a. FATHER'S NAME <u>Jacob Siegman</u>	13b. MOTHER'S MAIDEN NAME <u>Mary Shoehart</u>	14. NAME OF HUSBAND OR WIFE <u>unknown</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>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Hospital Records - Nevada, Mo.</u>	ADDRESS
--	-------------------------------------	---	---------

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pulmonary Tuberculosis</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		DA 2X	

19a. DATE OF OPERATION <u>None</u>	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
------------------------------------	----------------------------------	--

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
--	--	---

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
--	--	----------------------------

22. I hereby certify that I attended the deceased from Dec 22 -, 1950, to Dec 24, 1950, that I last saw the deceased alive on Dec 24, 1950, and that death occurred at 6:45 Pm., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>George M. Boteler, M.D.</u>	23b. ADDRESS <u>State Hospital #3</u>	23c. DATE SIGNED <u>12/24/50</u>
---	---------------------------------------	----------------------------------

24a. BURIAL CREMATION, REMOVAL (Specify)	24b. DATE <u>12-25-1950</u>	24c. NAME OF CEMETERY OR CREMATORY <u>unknown</u>	24d. LOCATION (City, town, or county) (State) <u>Springfield, Mo.</u>
--	-----------------------------	---	---

DATE REC'D BY LOCAL REG. <u>Dec 26-50</u>	REGISTRAR'S SIGNATURE <u>Nathum H. Yancy</u>	331	25. FUNERAL DIRECTOR'S SIGNATURE <u>Allen J. Hays</u>	ADDRESS <u>Nevada, Mo</u>
---	--	-----	---	---------------------------

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

(Licensed Embalmers' Statement on Reverse Side)

DIVISION OF HEALTH OF MO.
District No. 5 - Springfield

RECEIVED JAN 3 1951

Dist. File _____

Date Filed _____

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.

Student
Student Embalmer

Signed Allen T. Keys

Licensed Embalmer No. 11968

P. O. Address Nevada, 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.