

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

9802

FILED APR 12 1952

BIRTH NO.

REG. DIST. NO. 318

PRIMARY REG. DIST. NO. 1003

Registrar's No.

2905

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
b. CITY (If outside corporate limits, write RURAL and give town or TOWN St. Louis, Missouri)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1		d. STREET ADDRESS (If rural, give location) 4317 Swan Ave.	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
a. (First) SILAS		b. (Middle) W.	
c. (Last) CHAPMAN		(Month) (Day) (Year) MARCH 26, 1952	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Oct. 7, 1893
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Elevator Operator		11. BIRTHPLACE (State or foreign country) Missouri	
13a. FATHER'S NAME Almon Chapman		14. NAME OF HUSBAND OR WIFE Mae Bell Chapman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mae Bell Chapman 4317 Swan Ave.	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cor Pulmonale		INTERVAL BETWEEN ONSET AND DEATH	
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? H 2 H 3	
22. I hereby certify that I attended the deceased from 2-21-52, 19___, to 3-26-52, 19___, that I last saw the deceased alive on 3-26-52, 19___, and that death occurred at 7:50A m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) El. Catanzaro M.D.		23b. ADDRESS 1515 Lafayette Avenue	
23c. DATE SIGNED 3-26-52		24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	
24b. DATE Mar. 29, 1952		24c. NAME OF CEMETERY OR CREMATORY Laurel Hill Gardens	
24d. LOCATION (City, town, or county) St. Louis Co. Mo.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Kriegshauser 4226 S. Kingshighway Bl.	
DATE REC'D BY LOCAL REG. MAR 27 1952		REGISTRAR'S SIGNATURE J. Carl Smith M.D. (Licensed Embalmer's Statement on Reverse Side)	

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

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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....

Richard W. Stovesand

Signed.....
Student Embalmer

Licensed Embalmer No. 4007

P. O. Address.....

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.