

FILED JUL 18 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **21064**

BIRTH NO. _____ REG. DIST. NO. **38** PRIMARY REG. DIST. NO. **3006** Registrar's No. **179**

1. PLACE OF DEATH a. COUNTY BOONE		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE MISSOURI b. COUNTY JASPER	
b. CITY OR TOWN COLUMBIA		c. CITY OR TOWN CARTHAGE	
c. LENGTH OF STAY (in this place) 7 DAYS		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION ELLIS FISCHL STATE CANCER			
3. NAME OF DECEASED (Type or Print) a. (First) SAMUEL b. (Middle) BERT c. (Last) CHAPPELL		4. DATE OF DEATH (Month) (Day) (Year) 7-13-1955	
5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) SINGLE	8. DATE OF BIRTH 11-19-1871
9. AGE (In years last birthday) 83		10. KIND OF BUSINESS OR INDUSTRY BLACKSMITH	11. BIRTHPLACE (City and State or Foreign Country) CLARENCE, MICHIGAN
10a. USUAL OCCUPATION (This kind of work done during most of working life, even if retired)		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME WILLIAM CHAPPELL		13b. MOTHER'S MAIDEN NAME ELIZA ANN PRICE	
14. NAME OF HUSBAND OR WIFE NONE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME HOSPITAL RECORDS ADDRESS	
18. CAUSE OF DEATH - Enter only one cause per line for (a), (b), and (c)			
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Encephalomalacia of brain			INTERVAL BETWEEN ONSET AND DEATH 2 days
*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.			
ANTECEDENT CAUSES DUE TO (b) Cardiac arrest under anesthesia			2 days
DUE TO (c) Epidermoid carcinoma of skin of hand with metastases			5 years
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION 7-11-55	19b. MAJOR FINDINGS OF OPERATION As above		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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 7-6 , 19 55 , to 7-13 , 19 55 , that I last saw the deceased alive on 7-13 , 19 55 , and that death occurred at 10:50 Am., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Richard E. Johnson, M.D.		23b. ADDRESS Columbia, Mo.	23c. DATE SIGNED 7-13-55
24a. BURIAL, CREMATION, REMOVAL (Specify) Funeral	24b. DATE 7-13-55	24c. NAME OF CEMETERY OR CREMATORY Arthur's Cem.	24d. LOCATION (City, town, or county) (State) Jasper Co. Mo.
DATE REC'D BY LOCAL REG. July 13 1955	REGISTRAR'S SIGNATURE Mrs. R. E. Palmer	FUNERAL DIRECTOR'S SIGNATURE ADDRESS 31-10 Barber Funeral Service, Columbia, Mo.	

WRITE PLAINLY—USING UNFADING 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, Student Embalmer No. working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *J. W. Phillips*
Licensed Embalmer No. *488*

P. O. Address *Columbia*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.