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FILED JUL 1 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 24741

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 544 Registrar's No. 1475

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) Kirkwood		c. CITY OR TOWN Kirkwood	
c. LENGTH OF STAY (In this place) 3 Yrs		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. JOSEPH'S HOSP.		STREET ADDRESS (If rural, give location) 711 S Kirkwood Rd.	

3. NAME OF DECEASED (Type or Print) a. (First) CHARLES b. (Middle) CHAPMAN c. (Last) NAPIER	4. DATE OF DEATH (Month) (Day) (Year) 6-27-1955
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5. SEX W	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 9-13-1868	9. AGE (In years last birthday) 86	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, or last, if retired) Printer	10b. KIND OF BUSINESS OR INDUSTRY Commercial	11. BIRTHPLACE (City and State or Foreign Country) Franklin Co. Mo.	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME David Napier	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Bettie Napier
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. 492-01-7341A	17. INFORMANT'S SIGNATURE OR NAME Cliff Napier ADDRESS 223 Chestnut
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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, athermia, etc. It means the disease, injury, or complication which caused death.</i>	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Vase. Accident - old		INTERVAL BETWEEN ONSET AND DEATH 1 7 days
	ANTECEDENT CAUSES *Forbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerotic Heart Dis. DUE TO (c) old Myocardial Infarct		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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) 4200 (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **6-10, 1955**, to **6-27, 1955**, that I last saw the deceased alive on **6-27, 1955**, and that death occurred at **9:35 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE Jack L. Nagadon MD. (Degree or title)	23b. ADDRESS 601 S. Brentwood	23c. DATE SIGNED 6/27/55
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24b. DATE 6-30-1955	24c. NAME OF CEMETERY OR CREMATORY New Picker Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis Mo.
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DATE REC'D BY LOCAL REG. 6-29-55	REGISTRAR'S SIGNATURE Heber R. Smith	25. FUNERAL DIRECTOR'S SIGNATURE Frank Aldrich ADDRESS 7. Home Wilshire Groves Mo.
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(Licensed Embalmer's Signature on Reverse Side)

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 *M. J. B. Hunt*

Licensed Embalmer No. *362*

P. O. Address *1511 1/2*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.