

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-008784

STATE FILE NUMBER

FILED MAR 25 1959 Registration District No. 75 Primary Registration District No. 3815 Registrar's No. 17

300
1-57

4

1. PLACE OF DEATH a. COUNTY <u>C. Clinton</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>DeKalb</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Cameron</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Stewartsville</u> ° 320
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Sackman Rest Home</u>		Length of stay in 1b <u>14yr</u>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>L. Jane Chappell</u>			4. DATE OF DEATH Month Day Year <u>3-4-1959</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-13-1864</u>	9. AGE (In years last birthday) <u>94</u>	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Stewartsville, Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>

13a. FATHER'S NAME <u>Redding G. Chappell</u>		13b. MOTHER'S MAIDEN NAME <u>Angeline Hankins</u>		14. NAME OF HUSBAND OR WIFE <u>Miss Maysie Chappell, Cameron, Mo.</u>	
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. <u>no</u>	17. INFORMANT <u>Miss Maysie Chappell, Cameron, Mo.</u>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Coronary arteriosclerosis</u>		<u>20 yrs</u>
	DUE TO (c) <u>Generalized arteriosclerosis</u>		<u>30 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (but not related to the terminal disease condition given in PART I (c)) <u>4201</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.					

20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
---	--	---

21. I attended the deceased from 5-2-58 to 3-4-59 and last saw ^(last seen) alive on 1-24-59
Death occurred at 9:25 Pm m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>R. A. Compton DO</u>	22b. ADDRESS <u>Cameron Mo.</u>	22c. DATE SIGNED <u>3-6-59</u>
---	------------------------------------	-----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>3-7-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Stewartsville</u>	23d. LOCATION (City, town, or county) (State) <u>Stewartsville, Mo</u>
--	----------------------------	--	---

24. FUNERAL DIRECTOR <u>W.E. Summersfield</u>	ADDRESS <u>Stewartsville, Mo</u>	25. DATE RECD. BY LOCAL REG. <u>3-15-59</u>	26. REGISTRAR'S SIGNATURE <u>Francis D. Crawford</u>
--	-------------------------------------	--	---

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.

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 *W.E. Sumner Field*.....

Licensed Embalmer No. *3007*.....
P. O. Address *Stewartville*.....

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.