

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-022581

X FILED JUL 14 1959

Registration District No. 316 Primary Registration District No. 3059 Registrar's No. 268 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>St. Francois</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Francois</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Bonne Terre</u>		Length of stay in 1b	c. CITY OR TOWN <u>De Lassus</u>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Bonne Terre Hospital</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>Rose Augusta Chapman</u>			4. DATE OF DEATH Month Day Year <u>July 7 1959</u>		
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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>Feb. 4, 1955</u>	9. AGE (last birthday) <u>4</u>	IF UNDER 1 YEAR Months <u>5</u> Days <u>3</u> Hours <u></u> Min. <u></u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (City and state or country) <u>St. Louis, Missouri</u>	12. CITIZEN OF WHAT COUNTRY <u>U S A</u>
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13a. FATHER'S NAME <u>Daniel Calvin Chapman</u>	13b. MOTHER'S MAIDEN NAME <u>Margaret Pearl Irvin</u>	14. NAME OF HUSBAND OR WIFE <u>None</u>
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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) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT Address <u>D. C. Chapman Knob Lick, Mo.</u>
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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>Skull Fracture</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Injuries received in automobile collision</u>	
	DUE TO (c) <u>Multiple injuries</u>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>Collision of two automobiles</u>
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20c. TIME OF INJURY Hour <u>7:30</u> a.m. <u>XX</u> Month, Day, Year <u>7-7-59</u>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Public Highway</u>	20f. CITY, TOWN, OR LOCATION <u>Doerun</u>	COUNTY <u>St. Francois</u>	STATE <u>Mo</u>
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at <u>about 9:30 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <u>Bert G. Miller</u> (Degree or title) <u>Coroner</u>	22b. ADDRESS <u>Farmington, Mo.</u>	22c. DATE SIGNED <u>7/9/59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>7/9/1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Masonic Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Bismarck, Missouri</u>
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24. FUNERAL DIRECTOR <u>Shipman & Sons Bixmarck, Missouri</u>	25. DATE RECD. BY LOCAL REG. <u>July 9, 1959</u>	26. REGISTRAR'S SIGNATURE <u>Esther Rudloff</u>
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DOCUMENT

MEDICAL CERTIFICATION

STATEMENT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed John N. Shepard

Licensed Embalmer No. 488

P. O. Address Biomax

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to sign 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.