

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS FEB 8 1960 114

60-000226

1. PLACE OF DEATH a. COUNTY FRANKLIN		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY FRANKLIN	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN SULLIVAN		c. CITY OR TOWN SULLIVAN	
Length of stay in 1b 2 YRS		Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 122 W. SPRINGFIELD		d. STREET ADDRESS (If outside, give location) 122 W. SPRINGFIELD	
3. NAME OF DECEASED (Type or print) First Middle Last MARY AMELIA CHAPMAN		4. DATE OF DEATH Month Day Year JAN. 28 1960	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH AUG. 10, 1864
9. AGE (last birthday) 95		IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) SULLIVAN, Mo.
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME BURGESS ELDREDGE	
13b. MOTHER'S MAIDEN NAME DRUSCILLA FUNK		14. NAME OF HUSBAND OR WIFE WALTER C. CHAPMAN	
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. NO NE	
17. INFORMANT CORINNE HANSEN		Address SULLIVAN, Mo.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Progressive Cerebral Atrophy 6 mos. DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
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 type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input 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.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE 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 April 15, 1955 to Jan 28, 1960 and last saw her alive on Jan 26, 1960 Death occurred at 10:20 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Thomas G. Humphrey		22b. ADDRESS Sullivan, Mo.	
22c. DATE SIGNED 1/28/60		23a. NAME OF CEMETERY OR CREMATORY I.O.O.F. CEMETERY SULLIVAN Mo.	
23b. DATE JAN. 30, 1960		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR H.M. EATON SULLIVAN, Mo.		25. DATE RECD. BY LOCAL REG. 1-29-60	
26. REGISTRAR'S SIGNATURE Thomas G. Humphrey			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

