

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-024625

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 100 Primary Registration District No. _____ Registrar's No. 69

FILED #1 24 1961

1. PLACE OF DEATH a. COUNTY <u>Dart</u>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Dart</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Howards twp.</u>		Length of stay in 1b <u>22 yrs</u>	c. CITY OR TOWN <u>Edger Springs</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>(Watkins, Swsp.)</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>3 mi W of Edger Springs</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>Marcella Madge Chapman</u>			4. DATE OF DEATH Month Day Year <u>July 12 1961</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>1-17-1894</u>	9. AGE (last birthday) <u>67+</u>	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) <u>housework</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTH PLACE (City and state or country) <u>St Louis Mo</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>Wm O'Keefe</u>	13b. MOTHER'S MAIDEN NAME <u>Emma Butler</u>	14. NAME OF HUSBAND OR WIFE <u>-</u>	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or unknown) (If yes, give war or dates of service) <u>NO</u>	16. SOCIAL SECURITY NO. <u>-</u>	17. INFORMANT <u>Cleo Mary Slaski</u> Address <u>St Louis</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:		INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>
IMMEDIATE CAUSE (a) <u>Cardiac + pulmonary arrest</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Coronary occlusion</u>	
DUE TO (c) <u>Coronary thrombosis</u>		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>diabetes mellitus</u>	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
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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 Month, Day, Year a.m. p.m.		

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
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21. I attended the deceased from 1959 to 1961 and last saw her alive on July 16, 1961
Death occurred at 2:30 P. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>B.J. Myers Dc</u>	22b. ADDRESS <u>Licking, MO</u>	22c. DATE SIGNED <u>7-18-61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>7-18-1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cem</u>	23d. LOCATION (City, town, or county) (State) <u>St Louis Mo</u>
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24. FUNERAL DIRECTOR <u>Smith-Ferguson Licking Mo</u>	25. DATE RECD. BY LOCAL REG. <u>7/18/61</u>	26. REGISTRAR'S SIGNATURE <u>M.M. Stark, M.D. auc</u>
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DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

AUG 1 1961

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 Robert Ferguson

Licensed Embalmer No. 3945

P. O. Address Living

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.