

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-030619  
STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **7660**

AMENDED

FILED AUG 23 1961

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>			Length of stay in 1b	c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Park Lane Hospital</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>4344 Laclede Ave.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>John Fred Chapman</b>			4. DATE OF DEATH Month Day Year <b>August 16, 1961</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>9/4/1886</b>	9. AGE (last birthday) <b>74</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Schools</b>		11. BIRTHPLACE (City and state or country) <b>Saybrook, Ill.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>	
13a. FATHER'S NAME <b>Jess Chapman</b>			13b. MOTHER'S MAIDEN NAME <b>Mary Holts</b>		14. NAME OF HUSBAND OR WIFE <b>Minette Chapman</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Minette Chapman, 4344 Laclede Ave.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 hrs</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			DUE TO (b)		DUE TO (c) <b>331x</b>		
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 <b>1959</b> to <b>Aug 16-61</b> and last saw him alive on <b>Aug 15th '61</b> Death occurred at <b>9:20 pm</b> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>Clyde Kane M.D.</b>				22b. ADDRESS <b>706 Madison</b>		22c. DATE SIGNED <b>8-17-61</b>	
23a. BURIAL/CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>8-18-61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park Cemetery</b>		23d. LOCATION (City, town, or county) <b>St. Louis Co., Mo.</b>		(State)	
24. FUNERAL DIRECTOR <b>Albert H. Hoppe, Inc., 4700 Washington Blvd.</b>			ADDRESS	25. DATE RECD. BY LOCAL REG. <b>AUG 17 1961</b>	26. REGISTRAR'S SIGNATURE <b>Earl Smith M.D.</b>		

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 Harvey Kahle

Licensed Embalmer No. 4596

P. O. Address St Louis, M.

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.