SSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

ITMENT OF PUBLIC HEALTH AND WELFARE

-61-040575

STATE FILE NUMBER

AMENDED

Registration District No. 100 Primary Registration District No. _____ Registrar's No. 109

FILED NOV 16 1961

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY: Dent

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Watkins Twsp. Length of stay in 1b: Life

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: 5 mi. E. Edgar Springs Inside Limits Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Mo b. COUNTY: Dent

c. CITY OR TOWN: Edgarsprings Inside Limits Yes ☐ No ☒

d. STREET ADDRESS (If outside, give location): 5 Mi E. of Edgarsprings Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First: Joseph Middle: O'Keefe Last: Chapman

4. DATE OF DEATH Month: Nov Day: 12 Year: 1961

5. SEX: M

6. COLOR OR RACE: W

7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐

8. DATE OF BIRTH: 8-6-1961

9. AGE (last birthday)

IF UNDER 1 YEAR: Months 3 Days 6

IF UNDER 24 HR: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ✓

10b. KIND OF BUSINESS OR INDUSTRY: ✓

11. BIRTHPLACE (City and state or country): Houston Mo

12. CITIZEN OF WHAT COUNTRY: US

13a. FATHER'S NAME: Joseph L Chapman

13b. MOTHER'S MAIDEN NAME: Lillie Helms

14. NAME OF HUSBAND OR WIFE: ✓

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No

(If yes, give war or dates of service): ✓

16. SOCIAL SECURITY NO.: ✓

17. INFORMANT: Joseph L Chapman Address: Edgar Springs Mo

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiac & pulmonary arrest

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b): Acute respiratory arrest

DUE TO (c): bilateral lobar pneumonia

INTERVAL BETWEEN ONSET AND DEATH: 24 hours

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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

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 ☐ NOT WHILE AT WORK ☐

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 Dead on arrival to _____ and last saw her/him alive on _____

Death occurred at 2a AM m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): B.J. Myers D.O.

22b. ADDRESS: Licking, Mo

22c. DATE SIGNED: 11-12-61

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: 11-13-61

23c. NAME OF CEMETERY OR CREMATORY: ✓

23d. LOCATION (City, town, or county): St Louis (State): Mo

24. FUNERAL DIRECTOR: Smith-Ferguson ADDRESS: Licking Mo

25. DATE RECD. BY LOCAL REG.: 11/13/61

26. REGISTRAR'S SIGNATURE: M M Hart M.D. by Ame

(Licensed Embalmer's Statement on Reverse Side)

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_____ Signed Robert E Ferguson

Signature of Student Embalmer

Licensed Embalmer No. 3945

P. O. Address Licking

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