MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

4128

1. PLACE OF DEATH

County..... Registration District No. 791 File No. 750

Township..... Primary Registration District No. Registered No.

City St. Louis Mo (No. Mo Baptist Hospital St. ..... Ward)

2. FULL NAME William F. Chalfant

(a) Residence. No. 814 Hamilton St., 15 Ward. (If nonresident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	White	Married

5a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mary Chalfant

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 30-1862

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	66	8	15	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Printer

(b) General nature of industry, business, or establishment in which employed (or employer) Schapley Hdw.

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY) Penn

PARENTS

10. NAME OF FATHER Wm F. Chalfant

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Penn.

12. MAIDEN NAME OF MOTHER Martha

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Penn.

14. INFORMANT Holland F. Chalfant
(Address) Springfield Mo

15. FILED 15 1929 Mary C Stamper REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan. 14 1929

17. I HEREBY CERTIFY, That I attended deceased from 1-8-29, 19..., to 1-14, 1929, that I last saw h. ... alive on 1-14, 1929, and that death occurred, on the date stated above, at 10 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Presenile mental and physical deterioration (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Acidosis non Diabetic (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED Sth ness
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? No. DATE OF .....
WAS THERE AN AUTOPSY? No.
WHAT TEST CONFIRMED DIAGNOSIS? Clinical findings
(Signed) C J Farmer, M. D
, 19 (Address) Metropolitan Bldg

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Springfield Mo — DATE OF BURIAL Jan 17 1929

20. UNDERTAKER Lohmeyer Und Co — ADDRESS Springfield Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

THIS IS A PERMANENT RECORD

Dr. P. J.

Metropolitan Bldg. Jeff 8140

Res. 5819 Cabanne Cat. 8312