

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

4821

MAR 27 1930

1. PLACE OF DEATH

County Jackson
Township Blue
City Independence

Registration District No. 398
Primary Registration District No. 3919
(No. Auditorium Bldg)

File No.
Registered No. 57
St. Ward)

2. FULL NAME

Frank Wilson Chappelow

(a) Residence. No. 325 W. Sea Ave St. Ward.
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Martha Chappelow

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 10-13-1872

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
57 4 2

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Bookkeeper
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Reorganized Church of God

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)
Independence Ind.

10. NAME OF FATHER James R. Chappelow

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

12. MAIDEN NAME OF MOTHER Mary E. Cook

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

14. INFORMANT Mrs. Minnie Starnes
(Address) 824 S. Pleasant Indep Mo

15. FILED 2-17, 1930 F. L. Cook REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-15-1930

17. I HEREBY CERTIFY, That I attended deceased from [Signature] 1930
that he/she was h. alive on [Signature] 1930, and that death occurred, on the date stated above, at [Signature] m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Apoplexy
EPA
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CONTRIBUTORY (SECONDARY) Arteriosclerosis
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED?
IF NOT AT PLACE OF DEATH [Signature]

8 DID AN OPERATION PRECEDE DEATH? DATE OF [Signature]

WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) [Signature] M. D.

2/15, 1930 (Address) Independence Mo.

*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 Mound Grove
DATE OF BURIAL 2/18 1930

20. UNDERTAKER [Signature] ADDRESS Indep. 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.

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