

Registration District No. 291

Primary Registration District No.

1. PLACE OF DEATH: 1008

(a) County \_\_\_\_\_  
 (b) City or town St Louis  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
In route to brother's house  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
 In this community \_\_\_\_\_ years, months or days 20 yrs

3. (a) PRINT FULL NAME Silas Chappell 140

8. (b) If veteran, name war NO 3. (c) Social Security No. NONE

4. Sex Male 5. Color or race Colored 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Hattie Chappell 6. (c) Age of husband or wife if alive 58 years

7. Birth date of deceased 12 25 1874  
 (Month) (Day) (Year)

8. AGE: Years 64 Months 8 Days 17 If less than one day hr. min.

9. Birthplace Jefferson City Mo.  
 (City, town, or county) (State or foreign country)

10. Usual occupation Laborer

11. Industry or business \_\_\_\_\_

12. Name Unknown

13. Birthplace Unknown ?  
 (City, town, or county) (State or foreign country)

14. Maiden name Unknown ?

15. Birthplace Unknown ?  
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Hattie Chappell

(b) Address 44 52 Page Ave

17. (a) Burial (b) Date thereof 8-17-39  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St Peters Cem

18. (a) Signature of funeral director Ellis Funeral Home

(b) Address 2820 Stoddard St

19. (a) AUG 16 1939 (b) J. D. Probert  
 (Date received local registrar) (Signature of registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_  
 (c) City or town St Louis 21  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 2607 LUCAS Ave  
 (If rural, give location)

(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

20. DATE OF DEATH: Month Aug. day 11th  
 year 1939 hour 4 minute 15 P. M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
 that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
 and that death occurred on the date and hour stated above.

Immediate cause of death Thrombosis of Pulmonary Veins; Contrib: Pulmonary Fibrosis; Chronic Diffuse Nephritis.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature Alfred Perry (M. D. or other)

Address Deputy Coroner Date signed 8-14-39

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

FORM 1 X 9311

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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 *My self*

*Lonnie Boy King*, Registered Apprentice No. \_\_\_\_\_  
working under my personal supervision.

Signed

*Lonnie Boy King*

Licensed Embalmer No. *2946*

P. O. Address *St Louis Mo.*

**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 this body is not embalmed, above space should be left blank.**