

REGD OCT 14 1939
Registration District No. **1008**

Primary Registration District No. _____

1. PLACE OF DEATH: **3**
(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: **Stone Nursing Home**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: **1 week**
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME: **William H. Chapel 140**
3. (b) If veteran, name war: **No** 3. (c) Social Security No.: **Unknown**

4. Sex: **M** 5. Color or race: **W** 6. (a) Single, widowed, married, divorced: **W**
6. (b) Name of husband or wife: **unknown** 6. (c) Age of husband or wife if alive: _____ years
7. Birth date of deceased: **Sept. 12, 1866**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
72 **11** **26** hr. min.

9. Birthplace: **Dresden, Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation: **Engineer**

11. Industry or business: **Railroad**

MOTHER FATHER
12. Name: **Wm. H. Chapel**
13. Birthplace: **New York**
14. Maiden name: **Mary Atwater** (State or foreign country)
15. Birthplace: **New York**
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature: **Elizabeth Auden**
(b) Address: **3636a Gasconade**

17. (a) **Removal** (b) Date thereof: **9/9/39**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation: **Sedalia, Mo.**

18. (a) Signature of funeral director: **A. W. McLaughlin**
(b) Address: **2301 Lafayette Ave**

19. (a) **SEP 9 1939** (b) **J. F. Brodeur**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: **1**
(a) State: **Missouri** (b) County: _____
(c) City or town: **Sedalia** (If outside city or town limits, write "RURAL")
(d) Street No.: _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept.** day **8**
year **1939** hour **6** minute **45 P. M.**
21. I hereby certify that I attended the deceased from **July 28 '39**
_____ 19, to **Sept. 8 '39** 19, **39**
that I last saw him alive on **Sept. 7 '39** 19, **39**
and that death occurred on the date and hour stated above.

Immediate cause of death: **Congestive Heart Failure** Duration **weeks**
Che Myocarditis **years**
Arteriosclerosis **years**
Renal
Other conditions (include pregnancy within 3 months of death): _____
Major findings: _____
Of operations: _____
Of autopsy: _____
PHYSICIAN: _____
Underline the cause to which death should be charged statistically.

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: **A. D. Harrison** (M. D. or other) _____
Address: **1755 So. Grand** Date signed: **9-8-39**

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.

RECORDING BACK INK—MAKE A PERMANENT RECORD

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed

Paul A Keith

Licensed Embalmer No.

3612

P. O. Address

2317 Lafayette

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.