

No. 2
-13-40
17-39
X23159

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 571

JAN FEB 25 1941
Registration District No. 1003

Primary Registration District No. 1003

Registrar's No. 571

1. PLACE OF DEATH:

(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: Peoples Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 23 days
In this community about 23 years
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 3810 Cook Ave.
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 17th.
year 1941 hour 2:20 minute a. M.

21. I hereby certify that I attended the deceased from June 1, 1940 to January 17th, 1941
that I last saw him alive on January 16th, 1941
and that death occurred on the date and hour stated above.

Immediate cause of death myocarditis chronic
Due to _____

Due to ruled

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

Duration

2 yrs

10 yrs (?)

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 [Signature] (M. D. or other) [Signature]
Address 4500 Olive St. Date signed 1-17-41

3. (a) PRINT FULL NAME Clarence Chapman

3. (b) If veteran, name war _____ 3. (c) Social Security No. 702-10-9781

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

6. (b) Name of husband or wife Minnie Chapman 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased December 14th, 1869
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>71</u>	<u>1</u>	<u>3</u>	_____ hr. _____ min.

9. Birthplace Paducah / Kentucky
(City, town, or county) (State or foreign country)

10. Usual occupation Waiter- retired

11. Industry or business Railroad

12. Name Marshall Chapman

13. Birthplace Unavailable 4 (State or foreign country)

14. Maiden name Annie Carper

15. Birthplace Unavailable 4 (State or foreign country)

16. (a) Informant Minnie Chapman

(b) Address 3810 Cook Ave.

17. (a) Burial (b) Date thereof Jan. 20th 41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park Cem.

18. (a) Signature of funeral director Charles J. Gates

(b) Address 4107 Finney Ave.

19. (a) JAN 19 1941 (b) J. F. Bredbeck
(Date received local registrar) (Registrar's signature)

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

MOTHER FATHER

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.....

James A. Johnson

Registered Apprentice No.....

working under my personal supervision.

Signed *James A. Johnson*

Licensed Embalmer No.....

3522

P. O. Address 4107 Finney Ave.

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, fact should be so stated above.