. S. No. 2
OM—8-43
v. 5-17-39
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUL 28 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 23844

Registration District No. 97 Primary Registration District No. 5356 Registrar's No. 76

1. PLACE OF DEATH:

(a) County Dallas
(b) City or town Long Lane Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Wilson Tun
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... (Specify whether
In this community 50 yrs.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dallas 36
(c) City or town Long Lane Rural
(If outside city or town limits, write "RURAL")
(d) Street No. .....
(If rural, give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3. (a) PRINT FULL NAME ULYSSES S. CHAPMAN

3. (b) If veteran, name war .....
3. (c) Social Security No. .....

4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife .....
6. (c) Age of husband or wife if alive ..... years
7. Birth date of deceased Feb (Month) 3 (Day) 1866 (Year)

8. AGE:

Years	Months	Days	If less than one day
79	3	27	..... hr. ..... min.

9. Birthplace Maries Co (City, town, or county) Mo (State or foreign country)
10. Usual occupation farmer
11. Industry or business .....

FATHER
12. Name Esquire Chapman
13. Birthplace ..... (City, town, or county) Penn (State or foreign country)

MOTHER
14. Maiden name Ruth Agee
15. Birthplace ..... (City, town, or county) Kent (State or foreign country)

16. (a) Informant L. E. Chapman
(b) Address Phillisburg Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-31-45 (Month) (Day) (Year)
(c) Place: burial or cremation New Hope
18. (a) Signature of funeral director L. B. Jones
(b) Address Buffalo Mo
19. (a) June 28/45 (Date received local registrar) (b) Mrs. A. L. Hoover (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month May day 30 year 1945 hour 9 minute 45 A.M.

21. I hereby certify that I attended the deceased from Apr 1, 1945 to May 30, 1945 that I last saw him alive on May 30, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death ..... Duration
Chronic Nephritis
Due to .....
Due to .....
Other conditions .....
(Include pregnancy within 3 months of death)
Major findings:
Of operations 131 b
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? .....
(Specify type of place)
While at work? ..... (e) Means of injury .....

23. Signature J. V. Lindsay (M. D. or other) MD
Address ..... Date signed 6-16-45

1124 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 7
District File Number 6-45-717
Date Filed 7-25-45

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 [redacted] B. [illegible]

Licensed Embalmer No. 4322

P. O. Address Buffalo 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, fact should be so stated above.