No. 2
—2-43
5-17-39
X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

30731

FILED SEP 18 1945

State File No.

Registration District No. 157 Primary Registration District No. 5584 Registrar's No. 158

**1. PLACE OF DEATH:**

(a) County Jasper

(b) City or town Avilla-McDonald Twp.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
No street numbers in Avilla /
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community 4 years
years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Jasper 49

(c) City or town Avilla 0
(If outside city or town limits, write "RURAL")

(d) Street No. None 0
(If rural, give location)

(e) Citizen of foreign country? No. 0 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME WILLIAM LEE CHAPMAN

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Male 0

5. Color or race White

6. (a) Single, widowed, married, divorced Single 0

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased June (Month) 12, (Day) 1941 (Year)

8. AGE: Years 4 Months 2 Days 10 If less than one day hr. min.

9. Birthplace Jasper County, (City, town, or county) Mo. 0 (State or foreign country)

10. Usual occupation X

11. Industry or business

FATHER
12. Name Cloyd C. Chapman
13. Birthplace Jasper Co., (City, town, or county) Missouri 0 (State or foreign country)

MOTHER
14. Maiden name Glenna Honey
15. Birthplace Jasper Co. (City, town, or county) Missouri 0 (State or foreign country)

16. (a) Informant Mrs. Cloyd C. Chapman
(b) Address Avilla, Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-26-45 (Month) (Day) (Year)
(c) Place: burial or cremation Park Cemetery

18. (a) Signature of funeral director Ulmer Funeral Home
(b) Address Carthage, Missouri

19. (a) Aug. 25 '45 (Date received local registrar) (b) Elizabeth Coryslin (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Aug. day 22, year 1945 hour 3:25 minute A. M.

21. I hereby certify that I attended the deceased from Aug. 21, 1945 to Aug 22, 1945 that I last saw him alive on Aug 21, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Hemorrhage in bladder

Due to Pneumonia

Due to

Other conditions
(Include pregnancy within 3 months of death)

Duration 2 days

Major findings:
Of operations ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
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 Geo. H. Bragdon M.D.
Address Reeds, Mo. Date signed 8/24/45

1203

(Licensed Embalmer's Statement on Reverse Side)

45-8.722

## 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.....

Licensed Embalmer No. 2722

P. O. Address. Carthage

**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.**

S. No. 2B
5M—3-45
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

State File No. Oct

Registration District No. 157 Primary Registration District No. 5584 Registrar's No. 158

**1. PLACE OF DEATH:**

(a) County Jasper

(b) City or town Avilla McDonald Twp
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:

(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)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State (b) County

(c) City or town
(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** Wm Lee Chagman

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced S

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased June (Month) 12 (Day) 1945 (Year)

8. AGE: Years 4 Months 2 Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

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

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

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

**MEDICAL CERTIFICATION**

20. **DATE OF DEATH:** Month Aug day 22
year 1945 hour minute M.

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

| | Duration |
|---|---|
| Immediate cause of death | |
| Due to | |
| Due to | |
| Other conditions Bronchial Pneumonia (Include pregnancy within 3 months of death) | |

Major findings:
Of operations
Of autopsy 107

**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 Geo H Bragdon (M. D. or other)
Address Reeds Date signed 9/22-45

SUPPLEMENTARY

30731