No. 2
I—5143
5-17-39
I X36671

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

31409

State File No. 2

FILED SEP 29 1945

Registration District No. 317

Primary Registration District No. 3063

Registrar's No. 2260

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution: St. Louis County Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 32 days (Specify whether
In this community 6 wks years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis 96

(c) City or town Overland 13
(If outside city or town limits, write "RURAL")

(d) Street No. 2414 Eugene
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME William Chappell

3. (b) If veteran, name war World War II

3. (c) Social Security No. 415-10-5720

4. Sex M

5. Color race W

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

6. (b) Name of husband or wife Hortense High Chappell

6. (c) Age of husband or wife if alive 32 years

7. Birth date of deceased April (Month) 15 (Day) 1914 (Year)

8. AGE: Years 31 Months 5 Days 8 If less than one day hr. min.

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

10. Usual occupation Truck Driver

11. Industry or business Truck -Brashear Truck Co.

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

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

16. (a) Informant Thomas Chappell

(b) Address 2414 Entity, Overland, Mo.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 9-25-45 (Month) (Day) (Year)

(c) Place: burial or cremation Martin, Tennessee

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) 9-25-45 (Date received local registrar) (b) E. G. McGovran MD (Registrar's signature) 25a

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 23 year 1945 hour 11 minute 30 a M.

21. I hereby certify that I attended the deceased from Aug. 22, 1945 to Sept. 23, 1945 that I last saw him alive on Sept. 23, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Hemorrhage

Due to Fracture pelvis

Due to accident 170 c-8

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy Intussusception - old hemorrhage in space of retius

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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

(a) Accident, suicide, or homicide (specify) Accident 96

(b) Date of occurrence 8/22/45

(c) Where did injury occur? St. Chas. Rock. Rd. (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Public Road (Specify type of place)

While at work? Yes (e) Means of injury Auto Collision

23. Signature Donald O. Beirst (M. D. or other)

Address 601 Brentwood, Clayton Date signed 9-24-45

707

(Licensed Embalmer's Statement on Reverse Side)

OCT 24 1945

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.

NOV 8 1945

Signed. G. W. Wilkinson

Licensed Embalmer No. 3575

P. O. Address.....

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
M—3-45
1 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. 317 Primary Registration District No. 3063 Registrar's No. 2265

1. PLACE OF DEATH:

(a) County St Louis

(b) City or town Clayton
(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 years, months or days)

In this community

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 William Chappell

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 M

6. (b) Name of husband or wife

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

7. Birth date of deceased Aug (Month) 15 (Day) 1914 (Year)

8. AGE: Years 31 Months Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

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

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 Oct Day 23 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.

Immediate cause of death — Duration

Due to

Due to

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) Accident

(b) Date of occurrence 8-22-45

(c) Where did injury occur? 8000 St Chas Rd. (City or town) St Louis (County) Mo (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Public Highway (Specify type of place)

While at work? yes (e) Means of injury Truck Crash into telephone post

23. Signature Donald O. Burrot (M.D. or other) M.D.

Address 601 Brentwood Date signed 10/2/45

SUPPLEMENTARY

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED 1947

OCT 24 1945

31409

OCT 27 1945

NOV 8 1945