

No. 2
9-4-41
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **10061**

FILED MAR 27 1946

Registration District No. **431**

Primary Registration District No. **4.3.1.1-**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **Macon**
(b) City or town **La Plata**
(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 _____
In this community **Forty one years**
years, months or days.

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Macon**
(c) City or town **La Plata**
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? **NO** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **FRANKLIN A. Chappell**

(b) If veteran, name war **no** (c) Social Security No. **510-01-1227**

4. Sex **Male** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **married**
6. (b) Name of husband or wife **Lowell Chappell** 6. (c) Age of husband or wife if alive **63** years
7. Birth date of deceased **October 8, 1880**
(Month) (Day) (Year)

8. AGE: Years **65** Months **4** Days **7** If less than one day _____ hr. _____ min.

9. Birthplace **Branchport New York!**
(City, town, or county) (State or foreign country)

10. Usual occupation **Stationary Engineer**

11. Industry or business **Pipe Fabric**

12. Name **Benjamin Franklin Chappell**

13. Birthplace **New York!**
(City, town, or county) (State or foreign country)

14. Maiden name **Jennie Baker**

15. Birthplace **New York!**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. F. A. Chappell**

(b) Address **La Plata, Mo.**

17. (a) **Burial** (b) Date thereof **2-19-1946**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: **burial or cremation**

18. (a) Signature of funeral director **D. S. Christie**
(b) Address **La Plata, Mo.**

19. (a) **2-19-46** (b) **Mr. D. B. Triffin**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **2** day **15**
year **1946** hour **3** minutes **30 P** M.

21. I hereby certify that I attended the deceased from _____
_____ 19____, to _____ 19____

that I last saw him _____ alive on _____ 19____
and that death occurred on the date and hour stated above.

Immediate cause of death **From the accidental in-
haling of carbon monoxide**

Due to **gas while in his own garage**

Due to **inhalation of gas at August**

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 **2-15-46**

(c) Where did injury occur? **La Plata Macon Mo.**
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
about home in garage

While at work? **no** (Specify type of place) **Asphyxiation**
(e) Means of injury **inhalation**

23. Signature **Dr. Edward Carver** (Physician's name)
Address **Bevier, Mo.** Date signed **2/19/46**

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

8983

186

(Licensed Embalmer's Statement on Reverse Side)

MAR 29 1946

3-46-558
MAR 19 1946

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 *D. G. Christie*
Licensed Embalmer No. *1109*
P. O. Address *La Plata, 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.