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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 7 1947

Registration District No. 317

THE STATE BOARD OF HEALTH OF MISSOURI
# STANDARD CERTIFICATE OF DEATH

State File No. 3432

Primary Registration District No. 3070

Registrar's No. 229

**1. PLACE OF DEATH:**
(a) County ST LOUIS
(b) City or town WEBSTER GROVES
(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 ____ (Specify whether years, months or days)
In this community 4 YRS.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MISSOURI (b) County ST LOUIS 96
(c) City or town WEBSTER GROVES 7
(If outside city or town limits, write "RURAL")
(d) Street No. 668 AMELIA AVE 4
(If rural, give location)
(e) Citizen of foreign country? ____ (Yes or No) /
If yes, name country ____

3. (a) PRINT FULL NAME CHARLES ELLIOT CHAPMAN
3. (b) If veteran, name war WORLD WAR I.
3. (c) Social Security No. 499-12-5803
4. Sex MALE
5. Color or race WHITE
6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife ROBERTA V. CHAPMAN
6. (c) Age of husband or wife if alive 44 years
7. Birth date of deceased JANUARY 7 1897 (Month) (Day) (Year)

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 50 | — | 24 | — hr. — min. |

9. Birthplace KEYTESVILLE (City, town, or county) MISSOURI (State or foreign country)
10. Usual occupation SHOE SALESMAN FURNISH
11. Industry or business BOYDS GENTS SHOES
FATHER
12. Name CHARLES A. CHAPMAN
13. Birthplace KEYTESVILLE (City, town, or county) MISSOURI (State or foreign country)
MOTHER
14. Maiden name ARDENIA ELLIOTT
15. Birthplace KEYTESVILLE (City, town, or county) MISSOURI (State or foreign country)
16. (a) Informant MRS. CHARLES E. CHAPMAN
(b) Address 668 AMELIA AVE W.A.
17. (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof FEB 2 1947 (Month) (Day) (Year)
(c) Place: burial or cremation KEYTESVILLE MO.
18. (a) Signature of funeral director Parker and Co
(b) Address WEBSTER GROVES MO.
19. (a) 2-1-47 (Date received local registrar) (b) Ruth J. Allen MD (Registrar's signature) MSW

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month 1-31-1947 day ____ year ____ hour ____ minute ____ M.
21. I hereby certify that I attended the deceased from Sept 1945 ____, 19__, to 1-28-47, 19__; that I last saw him alive on Jan 28 1947, 19__; and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death: Coronary Sclerosis (Myocarditis Chr) | |
| Due to: Arteriosclerosis 93 | |
| 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) ____
(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 0
23. Signature W H Olmstead M.D. (M. D. or other)
Address 3720 Washington Date signed 2/1/47

(Licensed Embalmer's Statement on Reverse Side)

APR 2 1947

MAY 9 1947

SEP 24 1947

NOV 1 1947

**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 Leslie Welch.

Licensed Embalmer No. 4395

P. O. Address Webster Groves 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.**