

No. 2
-12-45
5-17-39
I X47070

FILED JUN 2 1947

Registration District No. **200**

Primary Registration District No. **5725**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **MACON**

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

(c) Name of hospital or institution: **Still-Hildreth Sanatorium**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **2 Mo 2 days**
(Specify whether years, months or days)

In this community **11**
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Iowa** (b) County **999**

(c) City or town **Clear Lake**
(If outside city or town limits, write "RURAL")

(d) Street No. **505 North 4th St.**
(If rural, give location)

(e) Citizen of foreign country? **No.** (Yes or No) **2**

If yes, name country _____

3. (a) PRINT FULL NAME **Edward F Chappell**

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 **Married**

6. (b) Name of husband or wife _____

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

7. Birth date of deceased **July 23 1879**
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
67	9	5	hr. _____ min. _____

9. Birthplace **Barrie Ont Canada**
(City, town, or county) (State or foreign country)

10. Usual occupation **Osteopath**

11. Industry or business _____

MOTHER { 12. Name **Lomis Chappell**

13. Birthplace **Aurora Ont. Canada**
(City, town, or county) (State or foreign country)

14. Maiden name **Charr Lake Rush**

15. Birthplace **Kettleby Ont Canada**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs EE Chappell**

(b) Address **Clear Lake Iowa**

17. (a) **Removal** (b) Date thereof **5-1-47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Clear Lake Iowa**

18. (a) Signature of funeral director **Albert Skinner**

(b) Address **Macon Mo**

19. (a) _____ (Date received local registrar)

(b) **Mrs Ruth M Neeley** (Registrar's signature) **10/5**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **28**
year **1947** hour **4** minute **50 A.M.**

21. I hereby certify that I attended the deceased from **Feb 18 1947** to **April 28 1947**
that I last saw him alive on **April 28 1947**
and that death occurred on the date and hour stated above.

Immediate cause of death **IN VOLUNTIONAL Melancholia**
7 MONTHS

Due to **CHRONIC Pyelitis**

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations **n 3A**

Of autopsy **17**

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 **2**

23. Signature **H. P. Hoyle D.D.** (M. D. or other)
Address **MACON MO** Date signed **4-28-47**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

X

JUN 2 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.....

Licensed Embalmer No.

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. May
Registrar's No. 190

Registration District No. 200 Primary Registration District No. 5725

1. PLACE OF DEATH:

(a) County Macou
(b) City or town Rural
(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 Illinois (b) County Carroll
(c) City or town Clear Lake Ia.
(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

Edward E. 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 July 23 1888
(Month) (Day) (Year)

8. AGE: Years 67 Months _____ Days _____ (Unless than one day) hr. _____ min. _____

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

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) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Year 1954 hour _____ minute _____ M. 28

21. I hereby certify that I attended the deceased from _____ 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 _____

Due to _____
Due to _____

Other conditions _____ (Include pregnancy within 8 months of death)

PHYSICIAN _____
Major findings: _____
Of operations _____
Of autopsy _____
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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature _____ (M. D. or other) _____
Date signed _____

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

SUPPLEMENTARY

18090