

No. 2  
M-2-43  
5-17-39  
X35697

FILED DEC 17 1947

Primary Registration District No. ~~3000~~ 2772

Registrar's No. 425

1. PLACE OF DEATH:  
 (a) County Callaway  
 (b) City or town Rural Shamrock  
(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) 70 years

2. USUAL RESIDENCE OF DECEASED:  
 (a) State MO (b) County Callaway  
 (c) City or town Rural  
(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 GEORGE ELTON CHAPMAN  
 (b) If veteran, name war \_\_\_\_\_  
 (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month Dec day 2  
 year 1947 hour 5 minute P  
 21. I hereby certify that I attended the deceased from July 20<sup>th</sup>  
1947 to Dec 2 1947  
 that I last saw him alive on Nov 30<sup>th</sup> 1947  
 and that death occurred on the date and hour stated above.

4. Sex M 5. Color or race W  
 6. (a) Single, widowed, married, divorced married  
 6. (b) Name of husband or wife Georgia L. Chapman  
 6. (c) Age of husband or wife if alive 28 years  
 7. Birth date of deceased: Feb 10 1875  
(Month) (Day) (Year)

Immediate cause of death: Arterio Sclerosis  
 Duration \_\_\_\_\_

8. AGE: Years 72 Months 9 Days 20  
 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_

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

10. Usual occupation: Farmer

11. Industry or business: General Farm Work

12. Name: James Chapman

13. Birthplace: Callaway Co MO  
(City, town, or county) (State or foreign country)

14. Maiden name: Sarah Jane Smith

15. Birthplace: Callaway Co MO  
(City, town, or county) (State or foreign country)

16. (a) Informant: Mrs. Georgia Chapman

(b) Address: Wellsville MO

17. (a) Rural (b) Date thereof: Dec 4 1947  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Wellsville MO

18. (a) Signature of funeral director: W. C. Kuhn

(b) Address: Wellsville MO

19. (a) Dec 8 1947 (b) James Maschhoff  
(Date received local registrar) (Registrar's signature)

Other conditions: \_\_\_\_\_  
(Include pregnancy within 3 months of death)  
 Major findings: AM  
 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?  
 While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_  
 23. Signature: A. J. Dyck (M. D. or other) \_\_\_\_\_  
 Address: Middletown MO Date signed \_\_\_\_\_

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

4  
0  
0

RECEIVED  
District Health Officer No. 9,  
District File Number  
Date Filed 12-17-97

12-17-97

MAY 13 1998

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 CC. Kuchner  
Licensed Embalmer No. 3059  
P. O. Address Wellsville 7

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.