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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED APR 9 1948

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

9516

State File No. \_\_\_\_\_

Registration District No. 238

Primary Registration District No. 5824

Registrar's No. 275

1. PLACE OF DEATH:

(a) County New Madrid, Co

(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 Life years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County New Madrid

(c) City or town 6 mi North E. New Madrid  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location) 72

(e) Citizen of foreign country? No (Yes or No) \_\_\_\_\_  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME James Arthur Chapman

3. (b) If veteran name (year) No.

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 12  
year 1948 hour 7 minute 30 P.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.

4. Sex MO 5. Color or race white

6. (a) Single widowed, married, divorced \_\_\_\_\_

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased Aug-8-1899  
(Month) (Day) (Year)

Immediate cause of death \_\_\_\_\_  
My exposure and shock as result of falling into deep flood water on my back

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

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

8. AGE: Years 48 Months 7 Days 4 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace New Madrid, Co. Mo. ( )  
(City, town, or county) (State or foreign country)

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

1826

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name James Franklin Chapman

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

14. Maiden name Elmy Wheel

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

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

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_ 72

(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 \_\_\_\_\_ 3

28. Signature [Signature] (M. D. or other) \_\_\_\_\_  
Address New Madrid Mo. Date signed 3/12/48

16. (a) Informant Spirley Chapman

(b) Address Belleville, Mo. Star R.

17. (a) Burial (b) Date thereof Mar 14, 1948  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Farmington Mo

18. (a) Signature of funeral director \_\_\_\_\_ Richard Hudco

(b) Address New Madrid Mo

19. (a) 3-15-48 (b) Helena Land Jones  
(Date received local registrar) (Registrar's signature)

ADDITIONAL SUPPLEMENTARY PHYSICIAN INFORMATION REQUESTED. Outline the cause to which death should be charged statistically.

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

RECEIVED

District Health Officer No. 120

District File Number 440-50

Date Filed 4-27-44

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.....

Allen C McSpadden, Registered Apprentice No. 512  
working under my personal supervision.

Signed *L. H. Higginbotham*

Licensed Embalmer No. 3803

P. O. Address. *New Market, Md.*

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. April  
Registrar's No. 278

Registration District No. 238 Primary Registration District No. 5824

1. PLACE OF DEATH:

(a) County New Madrid  
(b) City or town Russell  
(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)

3. (a) PRINT FULL NAME James A. Chapman

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.....

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

7. Birth date of deceased..... (Month) (Day) (Year)

8. AGE: Years 48 Months 7 Days 3 If less than one day hr. min.

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

10. Usual occupation.....

11. Industry or business.....

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)

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.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March Day 12 year 1948 hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... to....., 19..... that I last saw h..... alive on..... 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 Mar 12, 1948

(c) Where did injury occur? New Madrid, Co. MO (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? In Overflow Hotel of Mississippi B. H. N. E. New Madrid

While at work no (Specify type of place) (e) Means of injury.....

23. Signature Les Hedgepeth (M.D. or other) Cowan

Address New Madrid Date signed 4-21-48

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

SUPPLEMENTARY

S-9516

Handwritten notes, possibly including "The" and "to", are visible in the bottom left corner.