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FILED SEP 17 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

29562

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

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 52 PRIMARY REG. DIST. NO. 4078 Registrar's No. 60

1. PLACE OF DEATH a. COUNTY <u>Cape Girardeau</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: <u>Missouri</u> b. COUNTY: <u>Cape Girardeau</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Delta</u>	c. LENGTH OF STAY (in this place) <u>32 yrs</u>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Delta</u>	16
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Delta, Mo.</u>		d. STREET ADDRESS (If rural, give location) <u>20 N</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>John</u> b. (Middle) <u>Thomas</u> c. (Last) <u>Chapman</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Aug. 19, 1949</u>		
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>April 6, 1890</u>	9. AGE (In years last birthday) <u>59</u>	10. MONTHS <u></u>	11. DAYS <u></u>	12. HOURS <u></u>	13. MIN. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u></u>	11. BIRTHPLACE (State or foreign country) <u>Near Farmington, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>unk.</u>	13b. MOTHER'S MAIDEN NAME <u>unk.</u>	14. NAME OF HUSBAND OR WIFE <u>Ella Chapman</u>		
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Ella Chapman</u>		ADDRESS <u>Delta, Mo.</u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Occlusion</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 or 3 hrs.</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>high blood pressure.</u>			
	DUE TO (c) <u></u>			
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>4201</u>			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>none</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>none</u>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from Apr 2, 1946, to Aug 19, 1949, that I last saw the deceased alive on Aug 19, 1949, and that death occurred at 1:40 P.M., from the causes and on the date stated above.

23a. SIGNATURE (Name or title) <u>W. D. Davault, M.D.</u>	23b. ADDRESS <u>Delta</u>	23c. DATE SIGNED <u>no Aug 26-49</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Aug. 21, 1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Kenyon Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Delta, Mo.</u>
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DATE REC'D BY LOCAL REG. <u>Sept 5-49</u>	REGISTRAR'S SIGNATURE <u>D. G. Schubert</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>L. ...</u>	ADDRESS <u>Cape Gir, Mo.</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED 9-14-49

Health Officer No. 4  
File Number 949-12  
Date Filed

*Handwritten notes, possibly "Statement by Licensed Embalmer"*

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

Student Embalmer No.

working under my personal supervision.

Student .....  
Student Embalmer

Signed *Howard L. Hansen*

Licensed Embalmer No. *4122*

P. O. Address *Capitola, Oregon*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply, the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.