

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **27232**

FILED JUL 23 1953

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 590 Registrar's No. 1895

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

1. PLACE OF DEATH a. COUNTY St. Louis			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St. Louis		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN WELLSTON		c. LENGTH OF STAY (in this place) 47 yrs	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN WELLSTON		d. STREET ADDRESS (If rural, give location) 6334 Wagner Ave.
d. FULL NAME OF HOSPITAL OR INSTITUTION 6334 Wagner Ave.			d. STREET ADDRESS (If rural, give location) 6334 Wagner Ave.		
3. NAME OF DECEASED (Type or Print) a. (First) Susie b. (Middle) Ethel c. (Last) Chapman			4. DATE OF DEATH (Month) (Day) (Year) 7-3-53		
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH 9-9-1905	9. AGE (In years last birthday) 47	10. IF UNDER 1 YEAR Months 10 Days 23
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine-operator		10b. KIND OF BUSINESS OR INDUSTRY SMALL ARMS PLANT	11. BIRTHPLACE (State or foreign country) Washington, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Otto Allen		13b. MOTHER'S MAIDEN NAME Lottie Allen	14. NAME OF HUSBAND OR WIFE Virgil W. Chapman		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 488-18-7074	17. INFORMANT'S SIGNATURE OR NAME Virgil W. Chapman ADDRESS _____			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage				INTERVAL BETWEEN ONSET AND DEATH 24 hrs
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	ANTECEDENT CAUSES (b) none DUE TO (c) _____				
	II. OTHER SIGNIFICANT CONDITIONS (Conditions contributing to the death but not related to the disease or condition causing death.) none				
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 13 Jan., 1953 , to Death 1953 that I last saw the deceased alive on 29 June, 1957 and that death occurred at _____ m., from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) U. J. ... M.D.			23b. ADDRESS 4731 P. O. ...		23c. DATE SIGNED 6/25/53
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 7-10-53	24c. NAME OF CEMETERY OR CREMATORY Father Dickson	24d. LOCATION (City, town, or county) (State) Kirkwood Mo.		
DATE REC'D BY LOCAL REG. 7-8-53	REGISTRAR'S SIGNATURE Herbert R. Donke M.D.		25. FUNERAL DIRECTOR'S SIGNATURE Sneed Funeral Chapel ADDRESS 615 Easton Ave		

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.

Signed Leroy W. Bannister

Signed _____

Student Embalmer

Licensed Embalmer No. 4523

P. O. Address 3880 Eastern Ave

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.