

FILED AUG 6 - 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. 24368
7071

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST LOUIS		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST LOUIS 2229	
d. FULL NAME OF HOSPITAL OR INSTITUTION ST MARY'S Infirmary		d. STREET ADDRESS (If rural, give location) 222609 WALNUT ST.	
3. NAME OF DECEASED (Type or Print) a. (First) LOUIS b. (Middle) CHAPMAN c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) 7-27-54	
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) DIVORCED	8. DATE OF BIRTH 9-22-1874
9. AGE (In years last birthday) 79		10. DURING OCCUPATION (Give kind of work done during most of working life, even if retired) MINISTER	11. BIRTHPLACE (City and State or Foreign Country) VANBUREN ARK.
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY?
13a. FATHER'S NAME HENRY CHAPMAN		13b. MOTHER'S MAIDEN NAME AMANDA THOMAS	
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) NO	
16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS MRS Ruth Goodwin 2609 WALNUT	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Massive Pulmonary Embolization		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hrs.	
ANTECEDENT CAUSES *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		DUE TO (b) Chronic Bronchiectasis 5 Years	
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (c) Cor Pulmonale	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? 526X			
22. I hereby certify that I attended the deceased from July 22, 1954, to July 27, 1954, that I last saw the deceased alive on July 27, 1954, and that death occurred at 5 P. M., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Chas. P. Jordan, M.D.		23b. ADDRESS 2746 Franklin Ave	
23c. DATE SIGNED July 29, 1954			
24a. BURIAL, CREMATION REMOVAL (Specify) REMOVAL		24b. DATE 7-30-54	
24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State) FORTSMITH ARK.	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE JUL 30 1954 J. Earl Smith		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Bennie Love 3103 Washington	

Licensed Embalmer's Statement on Reverse Side

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

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

W. Claude Gordon

Licensed Embalmer No.

3489

P. O. Address

4575 Alder

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.