

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-025087
State File No.

FILED AUG 11 1958

115-116

BIRTH NO. _____ REG. DIST. NO. ~~3020~~ PRIMARY REG. DIST. NO. 3020 Registrar's No. 211

1. PLACE OF DEATH a. COUNTY FRANKLIN		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY FRANKLIN	
b. CITY (If outside corporate limits, write RURAL and give township) WASHINGTON		c. CITY OR TOWN SULLIVAN	
c. LENGTH OF STAY (in this place) 5 DAYS		d. Is residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. FRANCIS HOSP.		e. STREET ADDRESS (If rural, give location) 474 N. CHURCH ST.	

3. NAME OF DECEASED (Type or Print) a. (First) EFFIE b. (Middle) VIRGINIA c. (Last) CHAPMAN	4. DATE OF DEATH (Month) (Day) (Year) AUGUST 8, 1958
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5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH OCT. 26, 1888	9. AGE (In years) (last birthday) 69 Months 9 Days 12	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	11. BIRTHPLACE (City and State or Foreign Country) CUBA, MO.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME WALTER CHAPMAN	13b. MOTHER'S MAIDEN NAME MARY ELDRIDGE	14. NAME OF HUSBAND OR WIFE CLAUDE CHAPMAN
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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) NO	16. SOCIAL SECURITY NO. NONE	17. INFORMANT'S SIGNATURE OR NAME AILEEN ERNE, BOURBON, MO.	ADDRESS MO.
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary thrombosis		INTERVAL BETWEEN ONSET AND DEATH 1 day
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) General arterio-sclerosis DUE TO (c)		
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? NO
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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) 332x
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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?
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22. I hereby certify that I attended the deceased from **6/10**, 19**58**, to **8/8**, 19**58**, that I last saw the deceased alive on **8/7**, 19**58**, and that death occurred at **2:00 AM** from the causes and on the date stated above.

23a. SIGNATURE Doc La'ore M.D.	(Degree or title)	23b. ADDRESS Sullivan, Mo	23c. DATE SIGNED 8/8/58
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE AUG. 10, 1958	24c. NAME OF CEMETERY OR CREMATORY I.O.O.F. CEMETERY	24d. LOCATION (City, town, or county) (State) SULLIVAN MO.
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DATE REC'D BY LOCAL REG. 8/9/58	REGISTRAR'S SIGNATURE F. L. Stukman	25. FUNERAL DIRECTOR'S SIGNATURE W. L. Stukman	ADDRESS Sullivan, Mo.
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(Licensed Embalmer's Statement on Reverse Side)

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

8961 9 1 908

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..... Signature of Student Embalmer

Signed *J. A. Dempsey*.....

Licensed Embalmer No. *4772*.....

P. O. Address *Lucerne, N.Y.*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting. If this body is not embalmed, fact should be so stated above.