

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

2099

State File No. ....

FILED FEB 3 1954

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 224 PRIMARY REG. DIST. NO. 3646 Registrar's No. 6

|   |  |  |   |
|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Moniteau</u>  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <u>Missouri</u> b. COUNTY <u>Moniteau</u> |   |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>California</u>                                      |  | c. CITY OR TOWN <u>7 S.E. Tipton</u>   | d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| c. LENGTH OF STAY (in this place) <u>10 days</u>  |  | e. STREET ADDRESS (If rural, give location) <u>7 Miles S.E. Tipton</u>   |   |
| d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>Latham Hospital</u> |  |  |   |

|                                     |                      |                             |                          |  |
|-------------------------------------|----------------------|-----------------------------|--------------------------|--|
| 3. NAME OF DECEASED (Type or Print) | a. (First) <u>Ed</u> | b. (Middle) <u>Franklin</u> | c. (Last) <u>Chapman</u> | 4. DATE OF DEATH (Month) (Day) (Year) <u>Jan. 10th. 1954</u> |
|-------------------------------------|----------------------|-----------------------------|--------------------------|--|

|                    |                               |   |                                       |   |   |                                       |
|--------------------|-------------------------------|---|---------------------------------------|---|---|---------------------------------------|
| 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>Jan. 28, 1880</u> | 9. AGE (In years last birthday) <u>73</u> | IF UNDER 1 YEAR Months _____ Days _____ | IF UNDER 1 HR. Hours _____ Min. _____ |
|--------------------|-------------------------------|---|---------------------------------------|---|---|---------------------------------------|

|   |   |   |  |
|---|---|---|--|
| 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>Farm</u> | 11. BIRTHPLACE (City and State or Foreign Country) <u>Moniteau County, Missouri</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
|---|---|---|--|

|  |  |  |
|--|--|--|
| 13a. FATHER'S NAME <u>Wm Henry Chapman</u> | 13b. MOTHER'S MAIDEN NAME <u>Cinda Drake</u> | 14. NAME OF HUSBAND OR WIFE <u>Effie Chapman</u> |
|--|--|--|

|  |                                     |   |               |
|--|-------------------------------------|---|---------------|
| 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>Effie Chapman, Clarksburg, Mo. R.F.D</u> | ADDRESS _____ |
|--|-------------------------------------|---|---------------|

|  |   |  |                                  |
|--|---|--|----------------------------------|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>* This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION   |  | INTERVAL BETWEEN ONSET AND DEATH |
|  | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral hemorrhage</u>   |  | <u>1 week</u>                    |
|  | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <u>Generalized arteriosclerosis</u><br>DUE TO (c) _____ |  | <u>2 year</u>                    |
| II. OTHER SIGNIFICANT CONDITIONS<br>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) <u>331X</u> |
|--|--|---|

|   |  |                                  |
|---|--|----------------------------------|
| 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? _____ |
|---|--|----------------------------------|

22. I hereby certify that I attended the deceased from Aug 4, 1951, to Jan 10, 1954, that I last saw the deceased alive on Jan 10, 1954, and that death occurred at 8 A. M., from the causes and on the date stated above.

|  |                                    |                                 |
|--|------------------------------------|---------------------------------|
| 23a. SIGNATURE (Degree or title) <u>Kenyon Latham M.D.</u> | 23b. ADDRESS <u>California, Mo</u> | 23c. DATE SIGNED <u>1-10-54</u> |
|--|------------------------------------|---------------------------------|

|   |                                |  |   |
|---|--------------------------------|--|---|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 24b. DATE <u>Jan. 12, 1954</u> | 24c. NAME OF CEMETERY OR CREMATORY <u>Masonic Cemetery</u> | 24d. LOCATION (City, town, or county) (State) <u>Clarksburg, Mo</u> |
|---|--------------------------------|--|---|

|   |   |   |               |
|---|---|---|---------------|
| DATE REC'D BY LOCAL REG. <u>Jan 15 54</u> | REGISTRAR'S SIGNATURE <u>N. E. Poppey #DR 202</u> | 25. FUNERAL DIRECTOR'S SIGNATURE <u>James E. Richard - Tipton</u> | ADDRESS _____ |
|---|---|---|---------------|

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

(Licensed Embalmer's Statement on Reverse Side)

**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 *James E. Richardson*  
Licensed Embalmer No. *246*  
P. O. Address *Spitoe*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F  
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.