

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

Do not use this space.

13268

**1. PLACE OF DEATH**

County Jackson Registration District No. 399  
 Township Frank Primary Registration District No. 1002  
 City Kansas City (No. 3427 Chestnut)

File No. \_\_\_\_\_  
 Registered No. 15400  
 St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Samuel D. Chapman  
 (a) Residence. No. 3427 Chestnut St. Ward. \_\_\_\_\_  
 (Usual place of abode)  
 Length of residence in city or town where death occurred 40 yrs. mos. 11 da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Mrs. Sarah Chapman</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Feb. 4, 1855</u>		
7. AGE <u>73</u>	YEARS <u>1</u>	MONTHS <u>4</u>
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>Shoe Salesman</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____ (c) Name of employer _____		

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4/8/1928

17. I HEREBY CERTIFY That I attended deceased from 3-9-28 to 4-8-28 that I last saw him alive on 3/28/28 and that death occurred, on the date stated above, at \_\_\_\_\_.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Coronal Stenosis 930  
900 920  
dur term.  
 CONTRIBUTORY (SECONDARY) Chr. Degeneration  
 (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da.

**9. BIRTHPLACE (CITY OR TOWN)**

Not known  
 (STATE OR COUNTRY) Illinois

**10. NAME OF FATHER**

Samuel M. Chapman

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

Not known  
 (STATE OR COUNTRY) Kentucky

**12. MAIDEN NAME OF MOTHER**

Wm. Phineas

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

Not known  
 (STATE OR COUNTRY) Germany

**14. INFORMANT**

Mrs. Sarah Chapman  
 (Address) 3427 Chestnut St.

**15. FILED**

4/9/28 M. M. Crowe  
 REGISTRAR

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH: \_\_\_\_\_

**19. DID AN OPERATION PRECEDE DEATH?**

no DATE OF \_\_\_\_\_

**20. WAS THERE AN AUTOPSY?**

no

**WHAT TEST CONFIRMED DIAGNOSIS**

Chemical  
 (Signed) Wm. J. J. J., M. D.  
4/9, 1928 (Address) 1100 Chestnut St.

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.  
R. C. W.

**19. PLACE OF BURIAL, CREMATION, OR REMOVAL**

Cremation at  
Elmwood

**DATE OF BURIAL**

4/10/1928

**20. UNDERTAKER**

Freeman Mortuary  
Baltimore

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

K. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

11:30 A.M.

VI. 3925

815 Mount Road

Fort. New York, Virginia