

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

Do not use this space.

6675

**1. PLACE OF DEATH**

County Jackson  
Township Raw  
City K.C. Mo. (No. 2117 Swope Parkway, St. 15 Ward)

399

Registration District No.

Primary Registration District No.

File No.

Registered No.

840

**2. FULL NAME**

(a) Residence. No. 2117 Swope Parkway St. 15 Ward

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U.S., if of foreign birth?

yrs.

mos.

ds.

**PERSONAL AND STATISTICAL PARTICULARS**

**3. SEX**

M

**4. COLOR OR RACE**

W

**5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)**

Married

**5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF**

Alice Chapline

**6. DATE OF BIRTH (MONTH, DAY AND YEAR)**

Aug 7-1859

**7. AGE**

YEARS

MONTHS

DAY

IF LESS than 1 day, hrs. or min.

69

6

12

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work

Druggist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

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

(STATE OR COUNTRY)

Key

**10. NAME OF FATHER**

don't know

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

(STATE OR COUNTRY)

Key

**12. MAIDEN NAME OF MOTHER**

don't know

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

(STATE OR COUNTRY)

Key

**14.**

INFORMANT (Address)

Alice Chapline  
3523 Euclid K.C. MO

**15.**

FILED

2-20, 1929 M. M. Crow  
Asst REGISTRAR

2

**MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH (MONTH, DAY AND YEAR)** Feb 19 1929

**17. I HEREBY CERTIFY** That I attended deceased from Dec 1, 1928, to Feb 19, 1929, that I last saw him alive on Feb 18, 1929, and that death occurred, on the date stated above, at 7:45 a.m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**  
Chron. Interstential Nephritis  
131  
132.B

about (duration) 3 yrs. mos. ds.  
**CONTRIBUTORY (SECONDARY)** Uremic coma

(duration) 2 yrs. mos. ds.

**18. WHERE WAS DISEASE CONTRACTED?** 1290  
IF NOT AT PLACE OF DEATH

Did an operation precede death? no DATE OF

Was there an autopsy? no  
WHAT TEST CONFIRMED DIAGNOSIS? symptoms

(Signed) Rev. F. Berry, M. D.  
419, 1929 (Address) 715 Chamber Street Key West

\*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.

**19. PLACE OF BURIAL, CREMATION, OR REMOVAL** Walnut Grove  
**DATE OF BURIAL** 2-21 1929

**20. UNDERTAKER** Harry Roland  
**ADDRESS** Partridge

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

N. 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.

16  
1  
2  
2  
2

Key West

