

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

Do not use this space.

12480

**1. PLACE OF DEATH**

County Jackson

Registration District No. 298

Township Shaw

Primary Registration District No. 3019

City Independence (No. \_\_\_\_\_)

File No. \_\_\_\_\_

Registered No. 107

St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Sarah Margaret Chapman Rocky Wallace

(a) Residence. No. 1331 N. Main St., 2d Ward.

(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 female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov. 26, 1853

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
76 7 9

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work housewife  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
(c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) Hocking Co., Ohio  
(STATE OR COUNTRY)

10. NAME OF FATHER Warren Chapman

11. BIRTHPLACE OF FATHER (CITY OR TOWN) unknown  
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Sarah Wood

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) unknown  
(STATE OR COUNTRY)

14. INFORMANT ms. A. S. Noble  
(Address) 1116 N. Osage

15. FILED 4-7 1930 F. L. Cook

REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-4 1930

17. I HEREBY CERTIFY, That I attended deceased from Mich 1930, to April 4, 1929, that I last saw her alive on Apr 3, 1929, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Pulmonary Tuberculosis  
Chronic  
23A

(duration) 25 yrs. mos. ds.

**CONTRIBUTORY (SECONDARY)**

(duration) \_\_\_\_\_ yrs. mos. ds.

**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? clinical  
(Signed) J. H. Hecker, M. D.

Apr 6, 1930 (Address) Independence Mo

\*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 DATE OF BURIAL

Woodlawn 4/7 1930

20. UNDERTAKER ADDRESS

W. E. ...

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.

1930

20

