

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

Do not use this space.

14210

1. PLACE OF DEATH

County Jackson
Township Kan
City Kansas City (No. Duncan Home 3660 Summit)

Registration District No. 399
Primary Registration District No. 1002

File No. _____
Registered No. 1722
St. _____ Ward _____

2. FULL NAME

Katherine Chapman

(a) Residence. No. 824 W. 60 Terrace St. _____ Ward. Kansas City Kansas
(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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Dr. Joseph R Chapman

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 27th 1855

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
75 11 14

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Home
(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) Pennsylvania 2

10. NAME OF FATHER James R Parr

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

12. MAIDEN NAME OF MOTHER Ediza Jane Sloan

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

14. INFORMANT Mrs Lorette Terrell
(Address) 824 W. 60 Terrace KC. Mo

15. FILED 4/13, 1931 M. M. Croone
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 11th 1931

17. I HEREBY CERTIFY that I attended deceased from Apr 4, 1931, to April 11, 1931, that I last saw her alive on Apr 11, 1931, and that death occurred, on the date stated above, at 5:46 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Lobar pneumonia
13.5 (duration) _____ yrs. _____ mos. 4 ds.

CONTRIBUTOR Acute cystitis
(SECONDARY) (duration) _____ yrs. _____ mos. 7 ds.

18. WHERE WAS DISEASE CONTRACTED
NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? no DATE OF _____
WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?
Chert & Hershinger M.D.
413 (Address) 1500 Professional Bldg

*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
Highland Park Cemetery 4-14 1931

20. UNDERTAKER ADDRESS
Fairweather-Oberner 814 N. 7th

K. R. 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.

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

