

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

34861

State File No. _____

Registration District No. _____

Primary Registration District No. _____

Registrar's No. **3836**

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City, Mo.
(c) Name of hospital or institution:
622 Benton
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 Yrs.
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City, Mo.
(If outside city or town limits, write "RURAL")
(d) Street No. XXXXXXXXXX 622 Benton
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Mrs. Alice Chapin 150

8. (b) If veteran, name war no 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife Harry Chanin 6. (c) Age of husband or wife if alive no years

7. Birth date of deceased Nov. 18th, 1867
(Month) (Day) (Year)

8. AGE: Years 71 Months 10 Days 15 If less than one day _____ hr. _____ min.

9. Birthplace Albany Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation At Home

11. Industry or business _____

MOTHER FATHER
12. Name Joseph Edmundson
13. Birthplace Don't Know
(City, town, or county) (State or foreign country)
14. Maiden name Don't Know
15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature _____

(b) Address Reed Hotel

17. (a) Special Removal (b) Date thereof 10/6/39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Albany Mo.

18. (a) Signature of funeral director M. E. Dougherty

(b) Address 2315 Linwood Blvd.

19. (a) 10-4-39 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 4th.
year 1939 hour 8 minute 10 A.M.

21. I hereby certify that I attended the deceased from 4/21/38, 19____, to 10/4/39, 19____;
that I last saw him alive on 10/3/39, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death
Recurrent hemorrhage from lower bowel due to unknown cause (no acetate growth palpable)

Other conditions Amplified & senile psychotic state 12/3/39
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) no
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature R. Claffey (Dr. or other)
Address 11039 1/2 rd Date signed 10/4/39

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

WHILE FILLING IN THIS CERTIFICATE, PLEASE USE BLACK INK—MAKE 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.

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 me

_____, Registered Apprentice No. _____

working under my personal supervision.

Signed Ray E. Snow

Licensed Embalmer No. 2560

P. O. Address 2315 Lansing

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.