

38487

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSMISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

Registrar's No.

4251

Registration District No. 399

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson /
 (b) City or town Kansas City
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
K.C. General Hospital No. 1
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 4 days (Specify whether
 In this community 2 years years, months or days)

3. (a) PRINT FULL NAME Wilson Chapman 1553. (b) If veteran, name war No 3. (c) Social Security No. No4. Sex M. 5. Color or race W. 6. (a) Single, widowed, married, divorced M.6. (b) Name of husband or wife Elizabeth Chapman 6. (c) Age of husband or wife if alive Unk. years7. Birth date of deceased Jan. 2 1879
(Month) (Day) (Year)8. AGE: Years 60 Months 10 Days 5 If less than one day
hr. min.9. Birthplace Illinois
(City, town, or county) (State or foreign country)10. Usual occupation None /11. Industry or business 912. Name Wilson Chapman 913. Birthplace Unk. 9
(City, town, or county) (State or foreign country)14. Maiden name Florence Pettyjohn /
15. Birthplace Unk.
(City, town, or county) (State or foreign country)16. (a) Informant's own signature Record Clerk(b) Address K.C. Gen. Hospital17. (a) King City Mo (b) Date thereof Nov 7 39
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation King City Mo18. (a) Signature of funeral director W. J. Lee(b) Address King City Mo19. (a) Nov 7 1935 (b) M. J. W. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson
 (c) City or town Kansas City
 (If outside city or town limits, write "RURAL")
 (d) Street No. 6919 Prospect
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 7th
year 1939 hour 3 minute 20 P M.21. I hereby certify that I attended the deceased from Nov. 3
1939, to Nov. 7th, 1939;
that I last saw him alive on Nov. 7th 1939, 1939;
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Chronic glomerular nephritis
 Due to _____
131
 Due to _____

Other conditions Acute Trachea
(Include pregnancy within 3 months of death)
Pneumonia with congestionMajor findings: _____
Of operations _____Of autopsy See above

Underline the cause to which death should be charged statistically

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

(a) Accident, suicide, or homicide (specify) _____
 (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. J. DeMama (M. D. or other)
Address Supt. K. C. Gen. Hosp. Date 11-7-39

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING 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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed *W. M. Lee*

Licensed Embalmer No. 2539

P. O. Address King City Mo

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.