DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 11 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 5686
Registrar's No. 911

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 2 Mo. & 23 days (Specify whether
In this community Life years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City (If outside city or town limits, write "RURAL")
(d) Street No. 2921 Harrison (If rural, give location)
(e) If foreign born, how long in U. S. A.? ..... years.

3. (a) PRINT FULL NAME SMITH CHAPMAN
3. (b) If veteran, name war None
3. (c) Social Security No. None
4. Sex Male
5. Color or race Wh.
6. (a) Single, widowed, married, divorced Divorced
6. (b) Name of husband or wife Glenna Chapman
6. (c) Age of husband or wife if alive 34 years
7. Birth date of deceased November 3, 1880 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
59	3	24	hr. min.

9. Birthplace ..... (City, town, or county) Missouri ( ) (State or foreign country)
10. Usual occupation News Agent
11. Industry or business
FATHER
12. Name Robert Chapman
13. Birthplace ..... (City, town, or county) Virginia (State or foreign country)
MOTHER
14. Maiden name Catherine Carey
15. Birthplace ..... (City, town, or county) Ohio (State or foreign country)
16. (a) Informant's own signature Mrs. Lula Romine
(b) Address North Kansas City, Mo.
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 2-28-40 (Month) (Day) (Year)
(c) Place: burial or cremation Jefferson City, Mo.
18. (a) Signature of funeral director C. H. Blackman & Son
(b) Address City
19. (a) Feb. 28, 1940 (Date received local registrar) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 27th year 1940 hour 7 minute 35 A.M. M.

21. I hereby certify that I attended the deceased from 12-4-39, 19..., to 2-27-40, 19...; that I last saw him alive on 2-27-40, 19...; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Confluent left bronchopneumonia	
Due to Bronchiectasis 10 Ja	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy See above	

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

23. Signature P. F. De Maria M.D. (M. D. or other)
Address Supt. K.C. Gen. Hospital, K.C. Mo. Date signed 2-27-40

(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.

Rev. 5-17-39 I X19511

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.....

Licensed Embalmer No. 2244

P. O. Address.....

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.