

FILED JUL 15 1940

State File No.

Registrar's No.

2256

Registration District No.

Primary Registration District No.

1002

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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: Research Hosp  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community 15 yrs years, months or days)

3. (a) PRINT FULL NAME Miss Alice Chaffee

3. (b) If veteran, name war no 3. (c) Social Security No. 487-07-4829

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

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Nov 15 1893  
(Month) (Day) (Year)

8. AGE: Years 46 Months 6 Days 28 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Mrs. O  
(City, town, or county) (State or foreign country)

10. Usual occupation Machine Operator

11. Industry or business Rockwell

12. Name Thomas D. Chaffee

13. Birthplace Illinois  
(City, town, or county) (State or foreign country)

14. Maiden name Mary Paul

15. Birthplace mo  
(City, town, or county) (State or foreign country)

16. (a) Informant Thomas D. Chaffee

(b) Address 2507 - Lister

17. (a) Burial (b) Date thereof 6-3-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt Moriah Cem

18. (a) Signature of funeral director Mrs C. L. Justice

(b) Address 718 Franklin St. C. Mo

19. (a) June 2, 1940 (b) M. M. Crowe  
(Date received local registrar) (Registrar's signature)

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. 2705 Lister  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 31  
9 year 1940 hour 2 minute 30 P. M.

21. I hereby certify that I attended the deceased from Thurs 28  
1940 to Thurs 31 1940.  
that I last saw her alive on Thurs 31 1940.  
and that death occurred on the date and hour stated above.

Immediate cause of death Decomposed pneumonia Duration 2 da.

Due to Staphylococcus  
infection

Due to Intestinal obstruction  
volvulus

Other conditions Had teeth extracted  
(Include pregnancy within 3 months of death)

Major findings: 12, 21, 22  
Of operations \_\_\_\_\_

Of autopsy Pneumonia  
Staphylococcus - Intest. obst.

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?  
311

While at work?  (Specify type of place) (e) Means of injury 1

23. Signature D. E. ... (M. D. or other) 1  
Address 4800 E. 24th Date signed 6/1/40

Dr. Chm...  
Be. 6949  
1:30 to 5:00

**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 Donald P. Browning  
Licensed Embalmer No. 2924  
P. O. Address I. C. 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.