

RECEIVED OCT 18 1940

32193

State File No. \_\_\_\_\_

Registration District No. 398

Primary Registration District No. 3019

Registrar's No. 234

1. PLACE OF DEATH:

(a) County Jackson  
 (b) City or town Independence  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
Independence Sanitarium & Hospital  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution Three Days  
(Specify whether)  
 In this community 8 Years  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
 (c) City or town Independence  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 825 W. Maple Ave.  
(If rural, give location)  
 (e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 26  
 year 1940 hour 10 minute 00 P.M.  
 21. I hereby certify that I attended the deceased from 9/24  
1940 to 9/26 1940  
 that I last saw her alive on 9/26 1940  
 and that death occurred on the date and hour stated above.  
 Immediate cause of death: Bronchopneumonia  
Wound

Duration  
1 day  
1 day

Due to Acute & Chronic Cholera  
Septic, Cholerae, Cholerae  
Cholerae

Other conditions: 126  
(Include pregnancy within 3 months of death)  
 Major findings:  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_

PHYSICIAN  
 \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

8. (a) PRINT FULL NAME Mrs. Elizabeth France Chase

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

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

6. (b) Name of husband or wife Amos M. Chase 6. (c) Age of husband or wife if alive 78 years

7. Birth date of deceased May 13 1861  
(Month) (Day) (Year)

8. AGE: Years 79 Months 4 Days 13 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Housewife 4

11. Industry or business Home 4

MOTHER FATHER { 12. Name Thomas France

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

14. Maiden name Alice Carter

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

16. (a) Informant A. M. Chase

(b) Address 825 W. Maple Ave.

17. (a) Burial (b) Date thereof 9-29-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mound Grove Cemetery

18. (a) Signature of funeral director [Signature]

(b) Address 815 W. Maple

19. (a) Sept. 28/40 (b) J. L. Cook  
(Date received local registrar) (Registrar's signature)

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?  
360  
(Specify type of place) (e) Means of injury  
 23. Signature [Signature] (M. D. or other) \_\_\_\_\_  
 Address Independence, Mo Date signed 9/27/40

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

**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..... *Henry W. Stahl*  
Licensed Embalmer No. *3181*  
P. O. Address *Independence*

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

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