

Registration District No. **299**

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: **St. Joseph Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ years, months or days

3. (a) PRINT FULL NAME **ARTHUR V. CHAPMAN**
3. (b) If veteran, name war **none**
3. (c) Social Security No. **none**

4. Sex **male** 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 **June 29 1936**
(Month) (Day) (Year)

8. AGE: **4** Years **9** Months **28** Days If less than one day _____ hr _____ min

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

10. Usual occupation **Child**

11. Industry or business _____

MOTHER FATHER
12. Name **Theresa Houston Chapman**
13. Birthplace **St. Joseph Mo**
(City, town, or county) (State or foreign country)
14. Maiden name **Mrs. Ruth Coburn**
15. Birthplace **Wiedersale, Kansas**
(City, town, or county) (State or foreign country)

16. (a) Informant **Dorced V. Chapman**
(b) Address **#5 Independence Mo**
17. (a) Removal (burial, cremation, or removal) **removal** (b) Date thereof **4/29/41**
(Month) (Day) (Year)
(c) Place: burial or cremation **Wiedersale, Kans**

18. (a) Signature of funeral director **George E. Carson**
(b) Address **Independence Mo**
19. (a) **Apr 29 1941** (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 **Independence** 4
(If outside city or town limits, write "RURAL")
(d) Street No. **Route #5** 4
(If rural, give location)
(e) If foreign born, how long in U. S. A.? **1** years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Apr** day **27** year **1941** hour **12:15** minute _____ P. M.
21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death _____
Shen Sobral Kewenigo
Due to **Cerebral Trauma**
Due to _____
Other conditions **Alcohol** (include pregnancy within 3 months of death)

Major findings: _____
Of operations _____
Of autopsy **1102**

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) **Accident**
(b) Date of occurrence **4-27-41** 048
(c) Where did injury occur? **Jackson Mo**
(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 **Reseller** (M. D. or other) **3**
Address _____ Date signed _____

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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.....

.....
working under my personal supervision.

Registered Apprentice No.

Signed

Marion Steir

Licensed Embalmer No.

3156

P. O. Address

Indy 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, fact should be so stated above.