. S. No. 2
M—9-4-41
5-17-39
I X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 9017

FILED MAR 31 1943

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 1384

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. Tuberculosis Hospital 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6 months (Specify whether years, months or days)

In this community: 6 years

2. USUAL RESIDENCE OF DECEASED: 48

(a) State: Missouri (b) County: Jackson 3

(c) City or town: Kansas City 5
(If outside city or town limits, write "RURAL") 8

(d) Street No.: 4339 Garfield
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country: - 0

3. (a) PRINT FULL NAME: (ALPHONSO) Albert George Chaplik

3. (b) If veteran, name war: No

3. (c) Social Security No.: 708-10-0152

4. Sex: Male

5. Color or race: White

6. (a) Single, widowed, married, divorced: Married

6. (b) Name of husband or wife: Mrs. Ethel Chaplik

6. (c) Age of husband or wife if alive: 40 years

7. Birth date of deceased: July (Month) 26 (Day) 1900 (Year)

8. AGE: Years 42 Months 7 Days 23 25 If less than one day hr. min.

9. Birthplace: Omaha (City, town, or county) Nebraska (State or foreign country)

10. Usual occupation: Traffic Agent

11. Industry or business: C.G.W. Railway

FATHER
12. Name: Peter Chaplik
13. Birthplace: — (City, town, or county) Poland 4 (State or foreign country)

MOTHER
14. Maiden name: Mary Unknown
15. Birthplace: (City, town, or county) Minnesota 1 (State or foreign country)

16. (a) Informant: Mrs A. T. Chaplik
(b) Address: 4339 Garfield ave

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof: Mar. 23, 1943 (Month) (Day) (Year)
(c) Place: burial or cremation: Omaha, Nebraska

18. (a) Signature of funeral director: W. H. Newcomer Sons
(b) Address: 1401 Brush Creek Blvd.

19. (a) 3-22-43 (Date received local registrar) (b) M. M. Grove (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 21 year 1943 hour 8 minute 15 A. M.

21. I hereby certify that I attended the deceased from 9-9, 19 42, to 3-21, 19 43 that I last saw him alive on 3-21, 19 43 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Pulmonary Tuberculosis	11 mos.
Due to: 12 B	
Due to:	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations:
Of autopsy:

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: Matthew J. Hoon (M. D. or other)

Address: K.C.T.B. Hosp. Date signed 3/21/43

(Licensed Embalmer's Statement on Reverse Side)

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 C. Hervey Quisenber

Licensed Embalmer No. 40.70

P. O. Address R 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, fact should be so stated above.