

S. No. 2
M-2-43
5-17-39
I X35897

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

13088

State File No.

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 1823

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 29 days
(Specify whether)

In this community 60 years
(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. 15th & Troost
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country USA

3. (a) PRINT FULL NAME Frank Chapman

3. (b) If veteran, name war No record 3. (c) Social Security No. None

4. Sex Male 5. Color or Race W. 6. (a) Single, widowed, married, divorced Divorced

6. (b) Name of husband or wife No record 6. (c) Age of husband or wife if alive years

7. Birth date of deceased Oct. 22nd 1860
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 13th
year 1943 hour 5 minute 30 P. M.

21. I hereby certify that I attended the deceased from 3-15-43, 19... to 4-13-43, 19...
that I last saw him alive on 4-13-43, 19...
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day

82 5 22 hr. min.

Immediate cause of death Fracture of femur, accidental fall

Due to Senility

Other conditions (Include pregnancy within 3 months of death) Senility

Due to Senility

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

10. Usual occupation Not recorded

PHYSICIAN

Major findings: Of operations None

Of autopsy None

Underline the cause to which death should be charged statistically.

11. Industry or business Deceased

MOTHER { 12. Name Chapman

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

14. Maiden name Elinor Bilson

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

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Acc 123

(b) Date of occurrence 3-14-1943

(c) Where did injury occur? K.C. Jackson Mo
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Home

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

23. Signature Dwight R. Thom (M. D. or other)
Address Med. Dir. K.C. Gen. Hospital Date signed

16. (a) Informant Record clerk

(b) Address K.C. Gen. Hospital, K.C. MO.

17. (a) Removal (b) Date thereof 4/17/43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Katowille Chapel of Beth

18. (a) Signature of funeral director Brown

(b) Address 2719 L...

19. (a) 4-17-43 (b) Mr. M. Brown
(Date received local registrar) (Registrar's signature)

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.....

Ray E. Lewis

Licensed Embalmer No. 2560

P. O. Address. R. E. Lewis

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.