

Registration District No. **149**

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:
General Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **5 days**
(Specify whether years, months or days)

3. (a) PRINT FULL NAME

John Chase

3. (b) If veteran, name war **no**

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 **May 31 1867**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
76 3 7 hr. _____ min.

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

10. Usual occupation **Farmer**

11. Industry or business **Farming**

MOTHER FATHER {
12. Name **Joe Chase**
13. Birthplace **Ireland**
(City, town, or county) (State or foreign country)
14. Maiden name **McCormack**
15. Birthplace **New York**
(City, town, or county) (State or foreign country)

16. (a) Informant **James F. Mulligan**

(b) Address **General Hospital**

17. (a) **Removal** (b) Date thereof **Sep 25, 1943**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **St. E. College of Osteopathy & Surgery**

18. (a) Signature of funeral director **Joyce Funeral Home**

(b) Address **3146 Main St**

19. (a) **10-4-43** (b) **T. E. Brown**
(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. **2511 McGee**
(If rural, give location)
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept** day **8th**
year **1943** hour **2** minute **45** A.M.

21. I hereby certify that I attended the deceased from **Sept 19** to **Sept 20**, 19____, to _____, 19____; that I last saw him alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death **Broncho pneumonia**

Due to _____
Due to **107**

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy **See above**

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? _____

While at work _____ (Specify type of place) (e) Means of injury _____
23. Signature **T. E. Brown** (M. D. or public)
Address **23 M. Way** Date signed **9/10/43**

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 Paul S. Rowe

Licensed Embalmer No. 2347

P. O. Address J. E. 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.