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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 8 1944

Registration District No. 177

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 27915

Primary Registration District No. 5569

Registrar's No. 170

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Rural Brookings Township
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Raytown Road & Curtis /
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community 10 Days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Rural - Brookings Township
(If outside city or town limits, write "RURAL")

(d) Street No. Raytown Road & Curtis
(If rural, give location)

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

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3. (a) PRINT FULL NAME Lilie May Chappell

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife

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

7. Birth date of deceased 11 (Month) 29 (Day) 1872 (Year)

8. AGE: Years 71 Months 7 Days 16 If less than one day hr. min.

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

10. Usual occupation At Home

11. Industry or business

MOTHER FATHER

12. Name Sail Aulgur

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

14. Maiden name Unknown

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

16. (a) Informant Mr. O. I. Chappell

(b) Address Raytown Road & Curtis

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-17-1944 (Month) (Day) (Year)

(c) Place: burial or cremation Brooklings

18. (a) Signature of funeral director Mrs. C. L. Forster

(b) Address 918 Brooklyn K.C.Mo.

19. (a) 7-15-44 (Date received local registrar) (b) Mrs C. E. Sarom (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July 15thl day 15th. year 1944 hour 6 minute 45 A. M.

21. I hereby certify that I attended the deceased from 7/13/, 1944, to 7/15/, 1944 that I last saw her alive on 7/15/, 1944 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Hypostatic pneumonia	6/12/44
Due to cerebral hemorrage	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy None

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 J. P. Watt (M. D. or other) DO

Address 2603 E. 31st Date signed 6/15/44

1159

(Licensed Embalmer's Statement on Reverse Side)

Dr. J.P.Watt
2601 East 31st. WA 3107
1-6 p.m.

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 J. A. Herrick

Licensed Embalmer No. 3599

P. O. Address K 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.