

FILED NOV 14 1944
 Registration District No. **199**

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, Mo.**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
2616 Bellefontaine
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether
 In this community **2 1/2 years**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **Jackson**
 (c) City or town **Kansas City, Mo.**
(If outside city or town limits, write "RURAL")
 (d) Street No. **2616 Bellefontaine**
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Mrs. Emma Frances Chase
 3. (b) If veteran, name war **-- no**
 3. (c) Social Security No. **none**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Oct.** day **30**
 year **1944** hour _____ minute **10** A. M.

4. Sex **F** | 5. Color or race **W**
 6. (a) Single, widowed, married, divorced **Widow**
 6. (b) Name of husband or wife **George W. Chase**
 6. (c) Age of husband or wife if alive **Dec.** years
 7. Birth date of deceased **Aug. 17, 1855**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from
Oct 18, 1944 to **Oct 29**, 1944
 that I last saw her alive on **Oct. 30**, 1944
 and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	89	2	13	hr. _____ min.

Immediate cause of death **Coronary Thrombosis**
 Due to _____
 Due to _____

9. Birthplace **New York**
(City, town, or county) (State or foreign country)
 10. Usual occupation **Housewife**
 11. Industry or business **at Home**

Other conditions **94a**
(Include pregnancy within 3 months of death)
 Major findings:
 Of operations _____
 Of autopsy _____

MOTHER FATHER
 12. Name **Dennis C. Wright**
 13. Birthplace **New York**
(City, town, or county) (State or foreign country)
 14. Maiden name **No Record**
 15. Birthplace **No Record**
(City, town, or county) (State or foreign country)

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

16. (a) Informant **Harry Chase**
 (b) Address **2616 Bellefontaine, K.C. Mo.**
 17. (a) **Removed** (b) Date thereof **Oct. 30-44**
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **Slater, Mo.**
 18. (a) Signature of funeral director **John P Sheil**
 (b) Address **K. C. Mo.**
 19. (a) **10-30-44** (b) **J. E. Brown**
(Date received local registrar) (Registrar's signature)

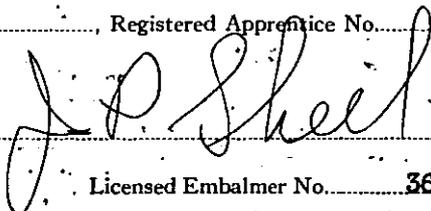
22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____
(City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
 While at work? _____ (Specify type of place)
 (e) Means of injury _____
 23. Signature **Harold A. Peltz** M. D. or other _____
 Address **1132 Prof. College** Date signed **10/30/44**

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.....



Licensed Embalmer No. 3625

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.