

FILED DEC 12 1945

Registration District No. _____

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: Trinity Lutheran Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 8 Hours
(Specify whether years, months or days)

In this community 8 Hours

3. (a) PRINT FULL NAME BABY CHAPMAN

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Female / 5. Color or race White

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased November 27 1945
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
-	-	-	<u>8</u> hr. <u>min.</u>

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

10. Usual occupation None

11. Industry or business _____

MOTHER { 12. Name Clarence A. Chapman

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

14. Maiden name Mildred Anderson

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

16. (a) Informant Clarence A. Chapman

(b) Address 3415 Genessee Street

17. (a) Cremation (Burial, cremation, or removal)

(b) Date thereof 11/30/ 1945
(Month) (Day) (Year)

(c) Place: burial or cremation Elmwood Cemetery

18. (a) Signature of funeral director Freeman Mortuary & Chapel

(b) Address 104 West 42nd Street

19. (a) 11-29-45 (Date received local registrar)

(b) Sheldine Holmes (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. 3415 Genessee Street
(If rural, give location)

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 27
year 1945 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from lived about 8 hours 19____
that I last saw h_____ alive on _____, 19____
and that death occurred on the date and hour stated above.

Immediate cause of death Premature 5 1/2 months

Due to _____

Due to _____

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

Major findings: 159

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? _____

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature J. J. Thomsen (M. D. or other)

Address 1730 Prof. Bldg. Date signed 11/28/45

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.....

No Embalming....., Registered Apprentice No.....
working under my personal supervision.

Signed *Walter H. Erwin*.....

Licensed Embalmer No. *4352*.....

P. O. Address *Kansas City, 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.