

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **20865**
Registrar's No. **2528**

FILED JUN 23 1947
149

Registration District No. **149** Primary Registration District No. **1002**

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: Osteopathic Hospital
(If not in hospital or institution, write street number & location)

(d) Length of stay: In hospital or institution 16 days (Specify whether years, months or days)

3. (a) PRINT FULL NAME Ada S. Chappel

3. (b) If veteran, name war nil

3. (c) Social Security No. 80

4. Sex Female **5. Color or race** white

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

6. (b) Name of husband or wife A. J. Chappel

6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased April 16 1892
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>55</u>	<u>1</u>	<u>25-24</u>	hr. min.

9. Birthplace Cosy Creek Ken
(City, town, or county) (State or foreign country)

10. Usual occupation House wife

11. Industry or business

12. Name John A. White

13. Birthplace Cosy Creek Ken
(City, town, or county) (State or foreign country)

14. Maiden name Mary Bernard

15. Birthplace Cosy Creek Ken
(City, town, or county) (State or foreign country)

16. (a) Informant A. J. Chappel

(b) Address Richmond MO

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

(b) Date thereof June 12-1947
(Month) (Day) (Year)

(c) Place: burial or cremation Highway slope Richmond, MO

18. (a) Signature of funeral director Geraldine Holman

(b) Address Richmond MO

19. (a) 6-10-47 **(b)** Geraldine Holman
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Ray 89

(c) City or town Richmond Rural 0
(If outside city or town limits, write "RURAL")

(d) Street No. 0
(If rural, give location)

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 10
year 1947 hour 11 minute 30-A M.

21. I hereby certify that I attended the deceased from May 24, 1947, to June 10, 1947
that I last saw her alive on June 10, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Uremic coma
1 week duration

Due to Bladder Neoplasm

Due to Banquet's Ball Bladder

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

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? no

While at work? _____ (Specify type of place)

(c) Means of injury 21

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

Address 9th St. Richmond, MO **Date signed** June 10, 1947

Duration _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

ADDITIONAL SUPPLEMENTARY INFORMATION

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

JUL 1 1961

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 *Shuman*

Licensed Embalmer No. 2073

P. O. Address Richmond, 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.

Registration District No. 149 Primary Registration District No. 1002

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: Cateopathic Hosp
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME Ada S. Chappel
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex _____ 5. Color or race _____ 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 _____ (Month) _____ (Day) _____ (Year)
8. AGE: Years _____ Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 6-10-47 (b) Theraldine Holmes
(Date received local registrar) (Registrar's signature)

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

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month June Day 10
year 1947 hour _____ minute 30 a.m.
21. I hereby certify that I attended the deceased from May 6-10 1947
to 6-10 1947
that I last saw him/her alive on _____ and that death occurred on the date and hour stated above.

Immediate cause of death: Extreme coma Duration 1 wk

Due to: glomerulonephritis

Due to: gangrenous gall bladder acute attack of chronic

Other conditions: cholecystitis (no stones)
(Include pregnancy within 3 months of death)

PHYSICIAN _____
Major findings: _____
Of operations: _____
Of autopsy: 127b
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 Joseph Yasso (M.D. or other) D.O.
Address 1726 E. 17th St Date signed 6-10-47

SUPPLEMENTARY

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

S-20865-