M—1/47
v. 5-17-39

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

National Office of Vital Statistics

FILED OCT 4 1947

STANDARD CERTIFICATE OF DEATH

State File No. 31463

Registration District No. 149 Primary Registration District No. 1005 Registrar's No. 4026

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 No. 1 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 11 days (Specify whether
In this community 53 years years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson 48
(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL")
(d) Street No. 3530 Penn 8
(If rural, give location) 0
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Chauncey P. Storm
3. (b) If veteran, name war xx
3. (c) Social Security No. None
4. Sex Ma 0
5. Color or race Wh
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Cora Mae Storm
6. (c) Age of husband or wife if alive xx years
7. Birth date of deceased December (Month) 10 (Day) 1872 (Year)

8. AGE: Years 74 Months 9 Days 11 If less than one day hr. min.
9. Birthplace Miles Point (City, town, or county) Mo. 0 (State or foreign country)
10. Usual occupation Retired Machinist
11. Industry or business
FATHER
12. Name Samuel J. Storm 9
13. Birthplace No Record (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Mary Ellen Heine
15. Birthplace No Record (City, town, or county) (State or foreign country) 9
16. (a) Informant Mrs. Mary Ellen Reeves
(b) Address 3530 Penn
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-24-47 (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Moriah
18. (a) Signature of funeral director J. W. Wagner
(b) Address Kansas City, Mo.
19. (a) 9-22-47 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 21
year 1947 hour 7 minute 25 P. M.
21. I hereby certify that I attended the deceased from Sept. 10, 1947 to Sept. 21, 1947; that I last saw him alive on Sept. 21, 1947; and that death occurred on the date and hour stated above.

Immediate cause of death Multiple decubitis ulcers-old cerebrovascular accident, left internal capsule with right hemiplegia; Lung abscess (non T.B.)
Due to
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings:
Of operations 830
Of autopsy See above

Duration

PHYSICIAN
Underline the cause of 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 0
23. Signature Wm W. Hart (M. D. or other) MD
Address Med. Dir. Gen'l Hosp. Date signed 9-22-47

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

Dr Rian-g

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 Cecil R. Matthes

Licensed Embalmer No. 3807

P. O. Address Kansas City M

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.