

FILED JUN 9 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. 17946
2512

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution, state name before admission) a. STATE <u>Mo</u> b. COUNTY <u>Platte</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>		c. LENGTH OF STAY (in this place) <u>3 da</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>9 W. 5th St.</u>		0850	
d. FULL NAME OF (If not in hospital, institution, give street address or location) HOSPITAL OR INSTITUTION <u>St. Lukes</u>				d. STREET ADDRESS (If rural, give location) <u>Parkville, Mo</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Irene</u>		b. (Middle) <u>Maud</u>		c. (Last) <u>Chappel</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>May 15 53</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED (Specify) <u>Never Married</u> WIDOWED, DIVORCED		8. DATE OF BIRTH <u>Dec 26 1948</u>	
9. AGE (In years, last birthday) <u>4</u>		10. KIND OF BUSINESS OR INDUSTRY <u>Child</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Los Angeles, Calif</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13a. FATHER'S NAME <u>Donald M. Chappel</u>		13b. MOTHER'S MAIDEN NAME <u>Frances L. Mendenhall</u>		14. NAME OF HUSBAND OR WIFE <u>None</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, specify branch) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Donald M. Chappel</u> ADDRESS <u>9 W. 5th St. Parkville</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Embolism</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Post-operative Pulmonary Thrombosis 24 hrs</u> DUE TO (c) <u>Post-operative for Tetralogy of Fallot 4 yrs</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>two hrs</u> <u>1540</u>	
19a. DATE OF OPERATION <u>5-14-53</u>		19b. MAJOR FINDINGS OF OPERATION <u>congenital heart disease Tetralogy of Fallot</u>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5-11</u> , 19 <u>53</u> , to <u>5-15</u> , 19 <u>53</u> , that I last saw the deceased alive on <u>7-15</u> , 19 <u>53</u> , and that death occurred <u>2:15 PM</u> <u>2:15</u> p.m., from the causes and on the date stated above.							
23a. SIGNATURE <u>Arnold V. Arms</u> (Degree or title) <u>Sus MD</u>				23b. ADDRESS <u>Kansas City, Mo</u>		23c. DATE SIGNED <u>5-16-53</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>cremation</u>		24b. DATE <u>May 18-53</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Elmwood Crematory</u>		24d. LOCATION (City, town, or county) (State) <u>Kansas City Mo</u>	
DATE REC'D BY LOCAL REG. <u>5-16-53</u>		REGISTRAR'S SIGNATURE <u>Beraldine Smith</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Leland H. Harris</u> ADDRESS <u>Parkville Mo</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

