

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-011345

FILED VS MAR 17 1960

146

Primary Registration District No.

3026

Registrar's No.

139

STATE FILE NUMBER

| | | | | | | | | |
|---|---|---|---|--|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Jackson | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Independence | | | Length of stay in 1b 57 yrs. | | c. CITY OR TOWN Independence | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1115 S. Leslie | | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) 1115 S. Leslie | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Raymond Middle James Last Chappelow | | | | 4. DATE OF DEATH Month March Day 4 Year 1960 | | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH 4-12-1887 | 9. AGE (last birthday) 72 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HR Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cabinetmaker | | | 10b. KIND OF BUSINESS OR INDUSTRY Builders Cabinet Co. | | 11. BIRTHPLACE (City and state or country) Cincinnati, Ohio | | 12. CITIZEN OF WHAT COUNTRY USA | |
| 13a. FATHER'S NAME Charles Chappelow | | | 13b. MOTHER'S MAIDEN NAME Lottie Creet | | | 14. NAME OF HUSBAND OR WIFE Velva Chappelow | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes, give war or dates of service) None | | | 16. SOCIAL SECURITY NO. no | | 17. INFORMANT Address William R. Chappelow 2717 S. Crvsler, Inde | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <input checked="" type="checkbox"/> Acute right heart failure | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 48 hrs. | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) <input checked="" type="checkbox"/> Chronic Constrictive heart failure | | DUE TO (c) <input checked="" type="checkbox"/> Chronic Emphysema | | | | years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | | | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) | | | | | | |
| 20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. | | | | | | | | |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 20f. CITY, TOWN, OR LOCATION | | COUNTY | STATE | |
| 21. I attended the deceased from 2/1/58 to 2/4/60 and last saw him alive on 3/4/60 Death occurred at 11:45 A.M. on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | |
| 22a. SIGNATURE (Degree or title) M. R. Spelman, D.O. | | | | 22b. ADDRESS 9140 E. 50 Highway KC 303 | | 22c. DATE SIGNED 3-8-1960 | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 3-7-1960 | 23c. NAME OF CEMETERY OR CREMATORY Woodlawn | | 23d. LOCATION (City, town, or county) Independence, Mo. | | 23e. STATE Mo. | | |
| 24. FUNERAL DIRECTOR Roland R. Speaks | | | ADDRESS Independence, Mo. | | 25. DATE RECD. BY LOCAL REG. 3-7-60 | 26. REGISTRAR'S SIGNATURE James S. Craig | | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Rollie Kessel

Licensed Embalmer No. 4690

P. O. Address Enders, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform with the above constitutes grounds for revocation of license).

- If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
- If this body is not embalmed, fact should be so stated above.