

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JUL 5 1960

-60-023098

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3205 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		c. CITY OR TOWN <b>Kansas City</b>	
Length of stay in 1b <u>10 yrs.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Mary's Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>16 W. 39th</b>	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>Divers</b> Middle <b>Bowls</b> Last <b>Chapman</b>			4. DATE OF DEATH Month <b>June</b> Day <b>16</b> Year <b>1960</b>			
--	--	--	--	--	--	--

5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>6-5-1898</b>	9. AGE (last birthday) <b>62</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>
-----------------------	----------------------------------	---	-------------------------------------	-------------------------------------	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Barber</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Muehebach Hotel</b>	11. BIRTHPLACE (City and state or country) <b>Holiday, Missouri</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
--	---	--	---

13a. FATHER'S NAME <b>David Chapman</b>	13b. MOTHER'S MAIDEN NAME <b>Maude Divers</b>	14. NAME OF HUSBAND OR WIFE <b>Flossie Chapman</b>
--	--	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>Unknown</b>	17. INFORMANT Address <b>Mrs. Flossie Chapman 16 W. 39th K.C. Mo.</b>
---	---	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u>		<u>4 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Coronary Arteriosclerosis</u>	<u>10 yrs.</u>
	DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Emphysema - Hypertension</u>	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 _____ a.m. _____ p.m.	Month, Day, Year
---	------------------

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 6-14-60 to 6-16-60 and last saw him alive on 6-15-60  
Death occurred at \_\_\_\_\_ on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Paul B. Burger, M.D.</u>	(Degree or title)	22b. ADDRESS <u>5949 Neman - Shawnee, K.</u>	22c. DATE SIGNED <u>6-17-60</u>
---	-------------------	---	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>6-16-1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Bethel Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Holiday, Missouri</b>
---	-------------------------------	--	---

24. FUNERAL DIRECTOR <b>Thompson Mackley</b>	ADDRESS <b>Madison, Missouri</b>	25. DATE RECD. BY LOCAL REG. <b>6-17-60</b>	26. REGISTRAR'S SIGNATURE <u>Irlva Marshall</u>
---	-------------------------------------	--	--

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Paul B. Burger

JUL 13 1960

VS JUL 5 - 1960

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 Joseph A. Mack  
Licensed Embalmer No. 1200

P. O. Address 4571

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.