MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-61-029166
STATE FILE NUMBER

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3775

FILED AUG 16 1961

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City
Length of stay in 1b 15 yrs.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 5900 East 43rd St
Inside Limits Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Jackson
c. CITY OR TOWN Kansas City
Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 5900 East 43rd St
Reside on Farm Yes ☒ No ☐

3. NAME OF DECEASED (Type or print) First: Almer Middle: E Last: Chapman
4. DATE OF DEATH Month: July Day: 29 Year: 1961
5. SEX Female
6. COLOR OR RACE White
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH Mar 26 1887
9. AGE (last Birthday) 74
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) Home wife
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (City and state or country) Nashville Tenn
12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME William Langston
13b. MOTHER'S MAIDEN NAME Unknown
14. NAME OF HUSBAND OR WIFE Minor Chapman
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None
16. SOCIAL SECURITY NO.
17. INFORMANT Minor Chapman Address 5900 E. 43rd. Kansas City Mo

MEDICAL CERTIFICATION

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)	Myocardial Insuffiency	1 day
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Essential Hypertension	10 years
DUE TO (c)	Herpes Zoster	3 months

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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 Jan 31, 1961, to July 29, 1961 and last saw her/him alive on July 29, 1961
Death occurred at 5:45 AM m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Carl T. Moore (Degree or title) D.O.
22b. ADDRESS 6425 E 37th K.C. 29. Mo
22c. DATE SIGNED 7-29-61

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal
23b. DATE 7/31/1961
23c. NAME OF CEMETERY OR CREMATORY Blue Springs Cem
23d. LOCATION (City, town, or county) Blue Springs (State) Mo

24. FUNERAL DIRECTOR Webb Funeral Home ADDRESS Blue Springs Mo
25. DATE RECD. BY LOCAL REG. 7-29-61
26. REGISTRAR'S SIGNATURE Ruth Long

(Licensed Embalmer's Statement on Reverse Side)

ITEM NO. | SHOULD READ | INSTEAD OF | DATE AMENDED

BY AFFIDAVIT OF DOCUMENTS ON THIS RECORD ARE AS FOLLOWS

Carl T. Moore

SEP 8 1967

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~~ _____, Student Embalmer No. _____

working under my personal supervision.

Student _____ Signed William Freer

Signature of Student Embalmer

Licensed Embalmer No. 4733

P. O. Address Blue Springs 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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