

No. 2
12-45
-17-39
X47070

FILED NOV 20 1946
Registration District No. 179

Primary Registration District No. 1001

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

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. 10
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 days
(Specify whether in this community 28 YEARS years, months or days)

3. (a) PRINT FULL NAME Ida May Chase

3. (b) If veteran, name war No

3. (c) Social Security No. NONE

4. Sex FEMALE Color or race WHITE

5. (a) Single, widowed, married, divorced WIDOWED

6. (b) Name of husband or wife MR. THOMAS L. CHASE

6. (c) Age of husband or wife if alive years

7. Birth date of deceased MARCH 15 1863
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>83</u>	<u>7</u>	<u>23</u>	hr. min.

9. Birthplace JOHNSON COUNTY KANSAS
(City, town, or county) (State or foreign country)?

10. Usual occupation AT HOME

11. Industry or business

MOTHER FATHER {

12. Name HENRY FINCH

13. Birthplace MISSOURI
(City, town, or county) (State or foreign country)

14. Maiden name OCTAVIA PORTER

15. Birthplace KENTUCKY
(City, town, or county) (State or foreign country)

16. (a) Informant MISS LENA O. CHASE

(b) Address 6908 PASEO

17. (a) BURIAL (b) Date thereof NOV-9-1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation ANTIOCH CEMETERY OYERLAND PARK, KANSAS

18. (a) Signature of funeral director J. N. Newcomer's Son

(b) Address 1401 BRUSH CREEK BLYD.

19. (a) 11-9-46 (b) I. Geraldine Holmes
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City
(If outside city or town limits, write "RURAL")

(d) Street No. 6908 Paseo
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 7
year 1946 hour 8 minute 43 A.M.

21. I hereby certify that I attended the deceased from Nov. 5, 1946 to Nov. 7, 1946;
that I last saw her alive on NOV. 7, 1946;
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage
Leukemia

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations See above

Of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(e) 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?

While at work? (Specify type of place) (e) Means of injury

23. Signature Wm W. Hart (M. D. or other) Med
Address Med. Dir. Gen'l Hosp. Date signed 11-7-46

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 *Melvin Miller*
Licensed Embalmer No. *4407*
P. O. Address *Lanier City, 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 this body is not embalmed, fact should be so stated above.