

FILED OCT 25 1947

State File No. _____

Registration District No. 179

Primary Registration District No. 1002

Registrar's No. 4335

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: MEMORAH HOSPITAL
(If not in hospital or institution, write street number or location)

(d) Length of stay: 1 WEEK
(Specify whether in this community years, months or days)

In this community LIFE
years, months or days

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. 600 WEST 67TH STREET
(If rural, give location)

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

3. (a) PRINT FULL NAME EDWIN K. CHAFFEE

3. (b) If veteran, name war NO

3. (c) Social Security No. 498-26-2775

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month OCTOBER day 15 year 1947 hour 5:00 minute A M.

21. I hereby certify that I attended the deceased from 9-16-47 to 10-15-47

that I last saw him alive on 10-15-47 and that death occurred on the date and hour stated above.

4. Sex MALE

5. Color or race WHITE

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

6. (b) Name of husband or wife MRS. JULIA K. CHAFFEE

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

7. Birth date of deceased JULY 4 1867
(Month) (Day) (Year)

Immediate cause of death Metastatic carcinoma of liver Duration _____

Due to Carcinoma of colon

8. AGE: Years 80 Months 3 Days 11 If less than one day hr. _____ min. _____

Due to _____

Other conditions (include pregnancy within 3 months of death) _____

9. Birthplace INDIANA
(City, town, or county) (State or foreign country)

Major findings: Of operations 4/6 Of autopsy _____

PHYSICIAN _____ Underline the cause to which death should be charged statistically.

10. Usual occupation RETIRED

11. Industry or business _____

12. Name CHAFFEE

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

14. Maiden name unknown

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

16. (a) Informant MRS. DAVID SIGHT

(b) Address 600 W 67th St

17. (a) CREMATION (b) Date thereof 10-17-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation ELMWOOD CEMETERY

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

(a) 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? _____

18. (a) Signature of funeral director STINE AND MCCLURE

(b) Address 2235 GILHAM PLAZA K.C. MO.

19. (a) 10-15-47 (b) Alfredine Holme
(Date received local registrar) (Registrar's signature)

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

23. Signature [Signature] (M. D. or other) M.D.
Address 10620 Prof Road Date signed 6/11/47

Dr. Priddy
Roth 12/21/19
R.P.M.

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 J. Clair Sheppard

Licensed Embalmer No. 4179

P. O. Address. 21 c 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.