

No. 2
2-45
17-39
X47070

FILED DEC 9 1947
1947

Registration District No. _____

Primary Registration District No. 1002

Registrar's No. 4960

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: K.C.T.B. HOSPITAL
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 mos - 27 days
(Specify whether years, months or days)

In this community 28 years
(Specify whether years, months or days)

3. (a) PRINT FULL NAME CHASE, LEVA OCTAVIA

3. (b) If veteran, name war No

3. (c) Social Security No. NONE

4. Sex FEMALE 5. Color or race WHITE

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

6. (b) Name of husband or wife unknown

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

7. Birth date of deceased NOVEMBER 14 1891
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

56 0 10 hr. min.

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

10. Usual occupation NONE

11. Industry or business AT HOME

12. Name CHASE, THOMAS CHARLES

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

14. Maiden name FINCH, MARY IDA

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

16. (a) Informant K.C.T.B. HOSPITAL

(b) Address LEEDS, MISSOURI

17. (a) BURIAL (b) Date thereof NOV 29 1947
(Burial, cremation, or removal) (City or town) (County) (State)

(c) Place: burial or cremation WEAR OVERLAND PARK ANTIPOCH CEMETERY KS.

18. (a) Signature of funeral director D.H. Newcomer's Sons

(b) Address 1401-BRUSH CREEK BLVD.

19. (a) 11-26-47 (b) Sheraldine 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 BLVD
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month NOVEMBER day 24
year 1947 hour 11:30 minute _____ P.M.

21. I hereby certify that I attended the deceased from 8-27, 1947, to 11-24, 1947
that I last saw h.e.r. alive on 11-24, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

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? _____

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

23. Signature William Ed May (M. D. or other) M.D.
Address K.C.T.B. Hospital Date signed 11-24-47

Duration

1 yr.

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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.....

John E. Fraking, Registered Apprentice No. *504*
working under my personal supervision.

Signed *Elmer Thomas*

Licensed Embalmer No. *1767*

P. O. Address *Kansas City*

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.