

FILED MAR 20 1948

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 966

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. 2  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 15 DAYS  
In this community 41 YRS.  
years, months or days (Specify whether)

3. (a) PRINT FULL NAME CHARLES CHIPLEY

3. (b) If veteran, name war no  
3. (c) Social Security No. 440-38-3570

4. Sex MALE  
5. Color or race NEGRO  
6. (a) Single, widowed, married, divorced 2 WIDOWED  
6. (b) Name of husband or wife Mary M. Chipley  
6. (c) Age of husband or wife if alive 26 years  
7. Birth date of deceased APRIL 1888  
(Month) (Day) (Year)

8. AGE: Years 59 Months 10 Days 3  
If less than one day hr. \_\_\_\_\_ min.

9. Birthplace NEW FRANKLIN MISSOURI  
(City, town, or county) (State or foreign country)

10. Usual occupation JANITOR

11. Industry or business \_\_\_\_\_

12. Name GEORGE CHIPLEY  
13. Birthplace NEW FRANKLIN MISSOURI  
(City, town, or county) (State or foreign country)  
14. Maiden name ALICE BURRIS  
15. Birthplace NEW FRANKLIN MISSOURI  
(City, town, or county) (State or foreign country)

16. (a) Informant EDNA BROWN (SISTER)  
(b) Address NEW FRANKLIN, MISSOURI

17. (a) Burial (b) Date thereof 3-3-1948  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Highland

18. (a) Signature of funeral director Mrs. J. W. Jones  
(b) Address 440 state ave. K. C. Kans.

19. (a) 3-2-48 (b) Stensidine 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. 2643 GARFIELD  
(If rural, give location)  
(e) Citizen of foreign country? NO (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month FEBRUARY day 29,  
year 1948 hour 7: minute 30 A.M.

21. I hereby certify that I attended the deceased from FEBRUARY 14, 1948 to FEBRUARY 29, 1948  
that I last saw him IM alive on FEBRUARY 29, 1948  
and that death occurred on the date and hour stated above.

Immediate cause of death TERMINAL BRONCHO-PNEUMONIA

Due to HYPERTENSIVE HEART DISEASE

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations: g3d  
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:

(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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)  
(a) Means of injury \_\_\_\_\_

23. Signature [Signature] M.D. or other M.D.  
Address GENERAL HOSPITAL NO. 2 Date signed 3/1/48

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

MOTHER FATHER

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**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

*E. Sterling Bull*

Licensed Embalmer No.

*31078*

P. O. Address

*1212 mile R.*

**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.**