

FILED AUG 1 - 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

24456  
STATE FILE NUMBER 3201

Registration District No. 199 Primary Registration District No. 1002 Registrar's No.

300  
-57

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>General Hospital</b>		Length of stay in lb <b>30 yrs.</b>	d. STREET ADDRESS <b>2625 Troost</b> (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Jack</b> Middle Last <b>Chapman</b>			4. DATE OF DEATH Month <b>July</b> Day <b>9</b> Year <b>1957</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-27-1924</b>		9. AGE (In years last birthday) <b>32 yrs</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>unknown</b>	11. BIRTHPLACE (City and state or country) <b>Aurora, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13a. FATHER'S NAME <b>Andrew L. Chapman</b>		13b. MOTHER'S MAIDEN NAME <b>Rose Seigrist</b>		14. NAME OF HUSBAND OR WIFE <b>none</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give year of service) <b>yes 1942-1947</b>		16. SOCIAL SECURITY NO. <b>499-14-7270</b>		17. INFORMANT Address <b>Andrew L. Chapman, 1218 E. 34th. K. C. Mo.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Basal Skull Fracture with subdural hematoma</b>					INTERVAL BETWEEN ONSET AND DEATH <b>89046<sub>45</sub></b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost. } DUE TO (b) _____ DUE TO (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					19. WAS AUTOPSY PERFORMED? <b>1 YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b>
20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in PART I or PART II of item 18.) <b>alleged to have fallen in a</b>			
20c. TIME OF INJURY Hour <b>7:57</b> Month <b>7</b> Day <b>57</b> Year <b>1957</b> a.m. p.m.		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>			
20e. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION <b>Kansas City</b>		COUNTY <b>Jackson</b>	STATE <b>MO</b>
21. I attended the deceased from _____ to _____ and last saw him or her alive on _____ Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>Hugh H. Owens</b> (Degree or title) <b>3</b>			22b. ADDRESS <b>1039 Parkside Bldg</b>		22c. DATE SIGNED <b>7-10-57</b>
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>7-11-1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Floral Hills Memorial Gardens Kansas City, Missouri</b>		23d. LOCATION (City, town, or county) (State)
24. FUNERAL DIRECTOR <b>Floral Hills Memorial Chapels Blue Ridge</b>			25. DATE RECD. BY LOCAL REG. <b>7-10-57</b>		26. REGISTRAR'S SIGNATURE <b>News Marshall</b>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 .....  
Signature of Student Embalmer

Signed *Garrett L. Seel* .....

Licensed Embalmer No. *4864* .....  
P. O. Address *Janson, Cal.* .....

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.