

Health,
& Welfare
Public
Service

STANDARD CERTIFICATE OF DEATH

40257
STATE FILE NUMBER
5546

FILED DEC 11 1957

Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

S. 300
1-57

| | | | | | |
|---|----------------------------------|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Jackson</u> | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>JACKSON</u> | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Kansas City</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN <u>KANSAS CITY</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) <u>FROST-AVG. NURSING INSTITUTION</u> | | | Length of stay in lb <u>4 1/2 YEARS</u> | | d. STREET ADDRESS (If outside, give location) <u>1322 BENTON BLYD.</u> |
| 3. NAME OF DECEASED (Type or print) First <u>MABEL</u> Middle <u>MAY</u> Last <u>CHAPMAN</u> | | | 4. DATE OF DEATH Month <u>NOV.</u> Day <u>23</u> Year <u>1957</u> | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>May 6, 1879</u> | 9. AGE (In years last birthday) <u>78</u> | IF UNDER 1 YEAR Months _____ Days _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) <u>Retired Registered Nurse</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) <u>Philadelphia, Penn. U.S.A.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
| 13a. FATHER'S NAME <u>John Reed</u> | | 13b. MOTHER'S MAIDEN NAME <u>Deborah Downton</u> | | 14. NAME OF HUSBAND OR WIFE <u>WILLIAM B. CHAPMAN</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>492-18-9103</u> | 17. INFORMANT <u>MRS. AGNES LITHGOW</u> Address <u>3311 FLORENCE AVENUE, KANSAS CITY, MISSOURI</u> | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>clm myocarditis</u> | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>arterio sclerosis</u> | | | | | |
| DUE TO (c) <u>unknown</u> | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4221</u> | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 20a. ACCIDENT <input 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.) | | |
| 20c. TIME OF INJURY Hour _____ a.m. _____ p.m. | | | 20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | |
| 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 20f. CITY, TOWN, OR LOCATION | | COUNTY | STATE |
| 21. I attended the deceased from <u>June 1, 1957</u> to <u>Nov 23, 1957</u> and last saw her alive on <u>Nov 23, 1957</u> Death occurred at <u>12:01 A.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE <u>M. B. Caspell M.D.</u> (Degree or title) | | | 22b. ADDRESS <u>4000 Palmdale</u> | | 22c. DATE SIGNED <u>11-23-57</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u> | | 23b. DATE <u>NOV. 24, 1957</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN CEM.</u> | | 23d. LOCATION (City, town, or county) (State) <u>VINTON, IOWA</u> |
| 24. FUNERAL DIRECTOR <u>D.W. NEWCOMER'S SONS</u> | | ADDRESS <u>1331-BAUGH CREEK KANSAS CITY, MO.</u> | | 25. DATE RECD. BY LOCAL REG. <u>11-23-57</u> | 26. REGISTRAR'S SIGNATURE <u>Neva Mindall</u> |

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION
M. B. Caspell M.D.



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 *Raymond M. Hardy*

Licensed Embalmer No. *4913* P. O. Address *Indian, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting. If this body is not embalmed, fact should be so stated above.