

Health,
& Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-033172
STATE FILE NUMBER

FILED OCT 15 1958 Registration District No. 150 Primary Registration District No. 5572 Registrar's No. 205

300
1-57

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Rural Prairie		c. CITY OR TOWN Kansas City 7000	
-Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		-Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Jackson Co. Hosp.		d. STREET ADDRESS (If outside, give location) Indep. Ave. & Brooklyn	
Length of stay in lb. 20 Yrs		Residence Form <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Fred Middle Chapman Last Chapman			4. DATE OF DEATH Month Oct. Day 3 Year 1958		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 24-1895	9. AGE (In years last birthday) 63	10. UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY General	11. BIRTHPLACE (City and state or country) Kansas City Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.	

13a. FATHER'S NAME Allen P. Chapman		13b. MOTHER'S MAIDEN NAME Minerva Dunn Cook		14. NAME OF HUSBAND OR WIFE *****	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Bessie May Clark Verona Mo.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of Oesophagus			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } 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? 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.) 2	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____		

20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE 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 Lees Summit Mo.	COUNTY _____ STATE _____
21. I attended the deceased from 8-4-1958 to 10-3-58 and last saw ^{him} alive on 10-3-58 . Death occurred at 7:05 P. m on the date stated above; and to the best of my knowledge, from the causes stated.			

22a. SIGNATURE (Degree or title) Fred Chapman M.D.		22b. ADDRESS Lees Summit Mo.		22c. DATE SIGNED 10-4-58
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 10/7/1958	23c. NAME OF CEMETERY OR CREMATORY Lees Summit	23d. LOCATION (City, town, or county) (State) Lees Summit Mo.	

24. FUNERAL DIRECTOR Langsford Funeral Home	ADDRESS Lees Summit Mo.	25. DATE RECD. BY LOCAL REG. 10/6/58	26. REGISTRAR'S SIGNATURE W. Langsford
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(Licensed Embalmer's Statement of Reverse Side)

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

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 *M. Blangford*
Licensed Embalmer No. *3133*
P. O. Address *Leis, Dummer*

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.