

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

34720
Do not use this space.

REC'D NOV 21 1938

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399
 (b) Township Kear Primary Registration District No. 1002 Registered No. 4056
 (c) City Kansas City (d) Street No. McCormick St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. 1 How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. 504 Bentish St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county of city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widower
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Kausera - Gilmore
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov 28, 1859
 7. AGE YEARS 78 MONTHS 10 DAYS 18 If LESS than 1 day, hrs. or min.
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. None
 9. Industry or business in which work was done, as saw mill, bank, etc. Retired
 10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

FATHER 13. NAME James Gilmore

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

MOTHER 15. MAIDEN NAME William Mullins

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

17. INFORMANT (ADDRESS) Charles A. Gilmore 2908 Arden

18. BURIAL, CREMATION, OR REMOVAL PLACE Mt Hope K.C. DATE Oct 18, 1938

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Wm. C. Foster 4 E. Broadway

20. FILED Oct 18, 1938 M. M. Crowe Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10-16, 1938

22. I HEREBY CERTIFY, That I attended deceased from 10-1, 1938 to 10-16, 1938
 I last saw him alive on 10-16, 1938 Death is said to have occurred on the date stated above, at 1:45 PM
 The principal cause of death and related causes of importance were as follows:

Hypertrophied Prostate; Post operative supra pubic cystotomy
 Other contributory causes of importance: Broncho pneumonia

Name of operation Date of 10-13-38
 What test confirmed diagnosis? Was there an autopsy? yes

23. If death was due to external causes (violence), fill in also the following
 Accident, suicide, or homicide? Date of injury 19.....
 Where did injury occur? (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury
 Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
 If so, specify (Signed) P. F. De Maria, M. D.
 (Address) Supr. McCormick Hosp. 1232

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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.....

Licensed Embalmer No.....

P. O. Address.....

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, above space should be left blank.