

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

9808

State File No. _____

1242

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. _____

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: Menorah Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 8 Months
(Specify whether
In this community 15 Years
years, months or days)

3. (a) PRINT FULL NAME Mrs. Catherine Helen Gailey

3. (b) If veteran, name war None
3. (c) Social Security No. None

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Mr. William T. Gailey
6. (c) Age of husband or wife if alive 50 years

7. Birth date of deceased May 2 1891
(Month) (Day) (Year)

8. AGE: Years Months Days
48 10 16 hr. min.
* If less than one day

9. Birthplace Shenandoah Iowa
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business ---

12. Name Andrew Simpson

13. Birthplace Unknown Unknown
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Unknown Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. William T. Gailey
(b) Address 1010 East 27th Street

17. (a) Burial (b) Date thereof March 26, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cemetery

18. (a) Signature of funeral director D. W. Neocomer

(b) Address 1401 Brush Creek Blvd.

19. (a) 3-20-40 (b) M. M. Crowder
(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. 1010 East 27th Street
(If rural, give location)
(e) If foreign born, how long in U. S. A? --- years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 18th
year 1940 hour 4 minute P. M.

21. I hereby certify that I attended the deceased from June 7 1939, 19 to March 18 1940,
that I last saw her alive on March 16 1940,
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic cancer be- ginning in the cervix uteri and later extending to the sacrum
Duration 4 1/2
Due to retention and into the
Due to ---

Other conditions (Include pregnancy within 3 months of death)

Major findings: benign of retention

Of autopsy None

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? _____

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

23. Signature Deo D. Chick, M.D. (M. D., or other)
Address 600 Professional Bldg Date signed 3-19-40

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

MOTHER FATHER

1600 Professional Bldg.
11-11-15, 2-5

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 C. Harvey Quisenberry
Licensed Embalmer No. 4070
P. O. Address K. C. 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 this body is not embalmed, above space should be left blank.