

AUG 14 1940

399

Primary Registration District No. 1002Registrar's No. 2729

1. PLACE OF DEATH:

(a) County Jackson
 (b) City or town Kansas City, Mo.
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution Leitch Litchman Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 3 days
 (Specify whether
 In this community Non-Resident
 years, months or days)

8. (a) PRINT
FULL NAMECharles M. Giles
CHARLES M. GILES. 4708. (b) If veteran,
name warNo8. (c) Social Security
No. No4. Sex M.5. Color
race White6. (a) Single, widowed, married,
divorced Married6. (a) Name of husband or wife
Marguerite Giles6. (c) Age of husband or wife if
alive 61 years

7. Birth date of deceased

Mar. 7, 1879

(Month) (Day) (Year)

8. AGE:

Years

Months

Days

If less than one day

6141

hr.

min.

9. Birthplace

Mound City, Kansas

(City, town, or county) (State or foreign country)

10. Usual occupation

Farmer

11. Industry or business

MOTHER FATHER

12. Name Daniel Giles13. Birthplace Jacksonville, Ill.14. Maiden name Mary Evans15. Birthplace Madisonville, Tenn.

16. (a) Informant's own signature

Mable M. Hayes

(b) Address

Lawton, Kansas17. (a) Removal

(b) Date thereof

July 8, 1940

(c) Place: burial or cremation

Lawton, Kan.

18. (a) Signature of funeral director

STINE McCLURE

(b) Address

K. C., Mo.19. (a) July 8, 1940(b) M. M. Crowe

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County Miami
 (c) City or town Oswatimie
 (If outside city or town limits, write "RURAL")
 (d) Street No. R.R. 2
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8th day July
 year 1940 hour 8 A.M. minute 10
 21. I hereby certify that I attended the deceased from June 30th
1940 to July 8 1940
 that I last saw him alive on July 8 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death Fractured femoral Duration _____

Due to Fractured hernia of
lens alba. Rupture of
perium near appendix.
 Due to _____

Other conditions
 (Include pregnancy within 3 months of death)

Major findings: gangrene of pyloric end
of stomach
profound necrosis of organ
distal end apparently normal
autopsied by oncologist
Y.S.

PHYSICIAN

 Underline
 the cause to
 which death
 should be
 charged sta-
 tistically.

22. If death was due to external causes, fill in the following:

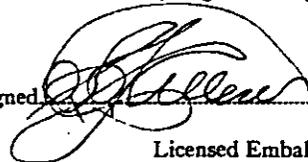
(a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence June 28-1930
 (c) Where did injury occur? On farm at Oswatimie, Kan.
 (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
On home farm
 While at work? Y.S. (Specify type of place) same party of
 (e) Means of injury back of head
fractured skull
 23. Signature Professional Body (M. D. or other) _____
 Address K. C., Mo. Date signed 7-8-40

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. 14615

P. O. Address K. C. 140

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.

CITY OF KANSAS CITY, MISSOURI
DEPARTMENT OF HEALTH

EDWIN HENRY SCHORER, M. D., DR. P. H.
DIRECTOR OF HEALTH

TENTH FLOOR CITY HALL

I wrote Dr. Dunn for an opinion on the coding of the attached case. In the reply the assignment is made to 175A which no doubt is the new classification, in which case - believe 202 would be the corresponding number of the old code which we are still using.

M. M.

*Paste on
back -*

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

2729

Registration District No.

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH:

(a) County.....
(b) City or town.....
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
.....
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
(Specify whether
In this community.....
years, months or days)

3. (a) PRINT FULL NAME.....

3. (b) If veteran, name war..... 3. (c) Social Security No.....

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

6. (b) Name of husband or wife..... 6. (c) Age of husband, or wife, if alive..... year.....

7. Birth date of deceased..... (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
61 hr. min.

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

10. Usual occupation.....

11. Industry or business.....

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

14. Maiden name.....
15. Birthplace..... (City, town, or county) (State or foreign country)

16. (a) Informant..... (b) Address.....

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

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address 7/8/40 M. M. Brown

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....
(c) City or town..... (If outside city or town limits write "RURAL")
(d) Street No..... (If rural, give location)
(e) If foreign born, how long in U. S. A.?..... years.

20. DATE OF DEATH.....

Month July day 8th
year 1940 hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 19..... to..... 19.....; that I last saw him..... alive on..... and that death occurred on the date and hour stated above.

Immediate cause of death: General peritonitis
traumatic hernia of lines alba-
perforation of cecum near appendix

Due to.....
Due to.....

Other conditions.....
(Include pregnancy.....)
Major findings: Gangrenal paroxysmal end of appendix with perforation of cecum
distal end apparently normal, surrounded by omentum.

Of operations.....
Of autopsy.....

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify).....
(b) Date of occurrence. June 28, 1940
(c) Where did injury occur? on farm at osawatome
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Home farm, struck in abdomen by some part of wheat binder.
While at work? Yes (e) Means of injury.....

23. Signature..... (M. D. or other).....

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

SUPPLEMENTARY