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rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED DEC 4 1944
1949

Registration District No. _____

Primary Registration District No. 1002

Registrar's No. 4725

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

1. PLACE OF DEATH:

(a) County Jacks on,

(b) City or town Kansas City,
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Osteopathical Hospital, 11th & Troost
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution since 7:30 pm 11-21-44
(Specify whether years, months or days)

In this community 1 Day 0
(Specify whether years, months or days)

3. (a) PRINT FULL NAME William Gagon

3. (b) If veteran, name war no

3. (c) Social Security No. # unknown

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Maurine L. Gagon

6. (c) Age of husband or wife if alive unknown years

7. Birth date of deceased 3-13-1918
(Month) (Day) (Year)

8. AGE: Years 26 Months 8 Days 8 If less than one day hr. min.

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

10. Usual occupation Milk Hauler

MOTHER FATHER

11. Industry or business _____

12. Name Wm. H. Gagon

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 Mrs. Lula Ling,

(b) Address Iola, Kansas.

17. (a) removal (Burial, cremation, or removal) (b) Date thereof 11-22-44
(Month) (Day) (Year)

(c) Place: burial or cremation Iola, Kansas

18. (a) Signature of funeral director Stine & McClure,

(b) Address 3235 Gilham Plaza, K. C., Mo.

19. (a) 11-24-44 (Date received from Registrar) (b) P. E. Brown (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County 929

(c) City or town Iola 14
(If outside city or town limits, write "RURAL")

(d) Street No. 425 No. Sycamore,
(If rural, give location)

(e) Citizen of foreign country? no. (Yes or No)

If yes, name country X

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 21st, year 1944 hour 9:44 minute P. M.

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

Immediate cause of death _____

Due to Tuberculous Meningitis

Due to Pulmonary Tuberculosis

Other conditions _____

Major findings: 13 15

Of operations _____

Of autopsy See Above

PHYSICIAN _____

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 _____

(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? _____

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

23. Signature A. E. Usher (M. D. of _____) MS

Address 23 Mcloy Date signed 11/24/44

DEC 20 1942

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 Robert H Reed

Licensed Embalmer No. 3745

P. O. Address Kansas City 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, fact should be so stated above.