

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

Registration District No. 149

Primary Registration District No. 1002

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

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution:  
409 E 4th St  
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Jackson <sup>48</sup>

(c) City or town Kansas <sup>3</sup>  
(If outside city or town limits, write "RURAL")

(d) Street No. 409 E 4th St <sup>6</sup>  
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Patrick Gillispic

3. (b) If veteran, name war None 3. (c) Social Security No. Do not know

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 25  
year 1945 hour 10 minute A. M.

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

4. Sex MO 5. Color or race W 6. (a) Single, widowed, married, divorced Do not know

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased: 1866  
(Month) (Day) (Year)

Immediate cause of death: Coronary occlusion

Due to arterio sclerosis

Due to \_\_\_\_\_

Other conditions (include pregnancy within 3 months of death): 9/40

8. AGE: Years 79 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace: Do not know 9  
(City, town, or county) (State or foreign country)

10. Usual occupation none

Physician: \_\_\_\_\_

Major findings: History + Inspection

Of autopsy no

11. Industry or business \_\_\_\_\_

12. Name Do not know 9

13. Birthplace Do not know 9  
(City, town, county) (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace Do not know 9  
(City, town, or county) (State or foreign country)

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? \_\_\_\_\_

16. (a) Informant Jackson County Coroner  
(b) Address K C MO

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-26-45  
(Month) (Day) (Year)

(c) Place: burial or cremation MT Calvary KC MO

18. (a) Signature of funeral director Passantino Bros  
(b) Address 13 E MO

19. (a) 1-25-45 (Date received local registrar) (b) D.E. Brown (Registrar's signature)

23. Signature James Walker 3 Brown  
(M. D. or other)

Address 6424 Profanity Rd Date signed 1-25-45

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**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, fact should be so stated above.**