

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH11843
State File No.

BIRTH NO.		REG. DIST. NO. <u>71</u>		PRIMARY REG. DIST. NO. <u>3012</u>		Registrar's No. <u>58</u>	
1. PLACE OF DEATH a. COUNTY <u>CLAY</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>CLAY</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>EXCELSIOR SPRINGS</u>		c. LENGTH OF STAY (in this place) <u>YRS</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>EXCELSIOR SPRINGS</u>			
d. FULL NAME OF (If not in hospital, institution, give street address or location) HOSPITAL OR INSTITUTION <u>EXCELSIOR SPRINGS HOSPITAL</u>				d. STREET ADDRESS (If rural, give location) <u>639 OLD ORCHARD</u>			
3. NAME OF DECEASED (Type or Print) <u>GLADYS</u>		a. (First)		b. (Middle) <u>BELLE</u>		c. (Last) <u>McKINNEY</u>	
4. DATE OF DEATH <u>APRIL 26, 1949</u>		(Month)		(Day)		(Year)	
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>APRIL 22, 1893</u>	
9. AGE (In years last birthday) <u>56</u>		10. MONTHS <u>0</u>		11. DAYS <u>4</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>BELLEVILLE, KANSAS</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>CALVIN H. MUNSELL</u>		13b. MOTHER'S MAIDEN NAME <u>IDA BELLE</u>		14. NAME OF HUSBAND OR WIFE <u>CURTIS S. McKINNEY</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT'S SIGNATURE OR NAME <u>CURTIS S. McKINNEY</u> ADDRESS <u>EX. SPRINGS, Mo.</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Carcinoma of colon</u> ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>15-3X</u>				INTERVAL BETWEEN ONSET AND DEATH <u>15 months</u>	
19a. DATE OF OPERATION <u>12-11-47</u>		19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma of colon (ascending) (Ruptured)</u>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) ... (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11-14</u> , 19 <u>46</u> , to <u>1-26</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>1-26</u> , 19 <u>49</u> , and that death occurred at <u>2:27</u> p.m., from the causes and on the date stated above.							
23a. SIGNATURE <u>E. C. Rohrbach M.D.</u> (Degree or title)		23b. ADDRESS <u>Excelsior Springs, Mo.</u>		23c. DATE SIGNED <u>4-26-49</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>APRIL 28 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>CROWN HILL</u>		24d. LOCATION (City, town, or county) (State) <u>EXCELSIOR SPRINGS, MO.</u>	
DATE REC'D BY LOCAL REG. <u>4/27/49</u>		REGISTRAR'S SIGNATURE <u>Baroline Hutchings</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Claude Prichard</u> ADDRESS <u>Excelsior Springs, Mo.</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

District Health Officer No: 61

District File Number

Date Filed 5-7-59

JUN 27 1959

JUN 11 1959

FEB 28 1956

JAN 15 1954

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

Student Embalmer No.

working under my personal supervision.

Signed

E. E. White

Signed.....
Student Embalmer

Licensed Embalmer No. 4168

P. O. Address Excelsior Springs

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.