

FILED APR 23 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

127738
State File No. 1586

BIRTH NO. _____ REG. DIST. NO. 199 PRIMARY REG. DIST. NO. 1002 Registrar's No. 1586

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY JACKSON	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN KANSAS CITY	c. LENGTH OF STAY (in this place) 30 YRS	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN KANSAS CITY	d. STREET ADDRESS (If rural, give location) 429 WEST DARTMOUTH ROAD
d. FULL NAME OF HOSPITAL OR INSTITUTION Memorial Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) Margaret	b. (Middle) G.	c. (Last) Todd.	4. DATE OF DEATH (Month) (Day) (Year) 4 6 1949
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5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH OCT-22-1894	9. AGE (In years last birthday) 54 YEARS	10. UNDER 1 YEAR Months	11. UNDER 48 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) CENTERVILLE, MISSOURI	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME JACK GIBBS	13b. MOTHER'S MAIDEN NAME ALBERTA HULL	14. NAME OF HUSBAND OR WIFE J. H. TODD
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. NONE	17. INFORMANT'S SIGNATURE OR NAME MR. J. H. TODD	ADDRESS 429 W. DARTMOUTH KANSAS CITY, MO.
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Uremia		INTERVAL BETWEEN ONSET AND DEATH 4 days
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.	DUE TO (b) Acute Hemorrhagic Pancreatitis	9 days	DUE TO (c) Acute Rupture of Gall bladder
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	gall stones(?)	9 days	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION not performed 584X	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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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?
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22. I hereby certify that I attended the deceased from Mar 27, 1949, to April 6, 1949, that I last saw the deceased alive on April 6, 1949, and that death occurred at 7:45 a.m., from the causes and on the date stated above.

23. SIGNATURE Phillip H. Halperin (Degree or title)	23b. ADDRESS 409 Prop Bldg	23c. DATE SIGNED April 6, 1949
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE APR 9-1949	24c. NAME OF CEMETERY OR CREMATORY FOREST HILL CEMETERY	24d. LOCATION (City, town, or county) (State) KANSAS CITY MISSOURI
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DATE REC'D BY LOCAL REG. 4-9-49	REGISTRAR'S SIGNATURE Geraldine Holmes	25. FUNERAL DIRECTOR'S SIGNATURE D.N. Newcomer	ADDRESS 1401 SAUNDERS CREEK BLVD KANSAS CITY, MO.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....
Student Embalmer

Signed *Bernard L. Moran*

Licensed Embalmer No. *4250*

P. O. Address *A.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, fact should be so stated above.