

FILED AUG 21 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **26903**

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. <u>3330</u>	
1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>Kansas City</u>		c. LENGTH OF STAY (In this place) <u>10 yrs.</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Kansas City</u>		40 70 2 8	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St Josephs Hosp.</u>				d. STREET ADDRESS (If rural, give location) <u>1317 West 42nd. St.</u>			
3. NAME OF DECEASED a. (First) <u>Lucy</u>			b. (Middle)			c. (Last) <u>Gleason</u>	
4. DATE OF DEATH (Month) (Day) (Year) <u>July 31 1949</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	
8. DATE OF BIRTH <u>4/8/1859</u>		9. AGE (In years last birthday) <u>90</u>		IF UNDER 1 YEAR Months Days		IF UNDER 11 HRS. Hours Min.	
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>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>US.</u>	
13a. FATHER'S NAME <u>Ed Rogers</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Peters</u>		14. NAME OF HUSBAND OR WIFE <u>Manford Gleason</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Nellie S. Henderson 1317 1/2nd St. Kansas City, 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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u> INTERVAL BETWEEN ONSET AND DEATH <u>at home 4-27-49 to 7-31-49</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last: DUE TO (b) <u>Chronic Atherosclerosis</u> DUE TO (c) <u>Myocardial Damage</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>✓</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>none</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>at home</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>K.C. Jackson, Mo. Mo.</u>		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>4-27-49 m.</u>	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>fell in the home on the floor</u>					
22. I hereby certify that I attended the deceased from <u>4-27</u> , 19 <u>49</u> , to <u>7-31</u> , 19 <u>49</u> , that I last saw the deceased <u>alive</u> on <u>7-31</u> , 19 <u>49</u> , and that death occurred at <u>3 P.</u> m., from the causes and on the date stated above.							
23a. SIGNATURE <u>M. F. Sewell</u> (Degree or title) <u>M.F. Sewell</u>				23b. ADDRESS <u>1722 W 39th St. Mo</u>		23c. DATE SIGNED <u>8-1-49</u>	
24a. BURIAL, CREMATION (REMOVAL) (Specify) <u>BURIAL</u>		24b. DATE <u>8/3/49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Monticello Cem.</u>		24d. LOCATION (City, town, or county) (State) <u>Monticello Kansas</u>	
DATE REC'D BY LOCAL REG. <u>8-2-49</u>		REGISTRAR'S SIGNATURE <u>Geraldine Holmes</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Gates Funeral Home</u>		ADDRESS <u>K. C. Kans.</u>	

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

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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 \_\_\_\_\_

..... Student Embalmer No. ....

working under my personal supervision.

Student .....  
Student Embalmer

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.**