

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **30332**
Registrar's No. **3810**

FILED SEP 23 1949

BIRTH NO. **42687-49** REG. DIST. NO. **149** PRIMARY REG. DIST. NO. **1002**

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

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) 2 mos. 7 days	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Independence	
d. FULL NAME OF HOSPITAL OR INSTITUTION Childrens Mercy Hosp		d. STREET ADDRESS (If rural, give location) 423 E. Kansas	
3. NAME OF DECEASED (Type or Print) a. (First) Gary b. (Middle) Dale c. (Last) Hoyt		4. DATE OF DEATH (Month) (Day) (Year) Sept. 2 - 1949	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Child	8. DATE OF BIRTH June 25, 1949
9. AGE (In years last birthday) 2 Months 7 Days		9. AGE (In years last birthday) 2 Months 7 Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	

13a. FATHER'S NAME Marion Hale Hoyt	13b. MOTHER'S MAIDEN NAME Ruby Bratcher	14. NAME OF HUSBAND OR WIFE —
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Marion Hoyt - Indep. Mo.
17. ADDRESS		17. ADDRESS

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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute gastroenteritis		
	II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i> Pulmonary atelectasis		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	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 **June 25, 1949** to **Sept. 2, 1949** that I last saw the deceased alive on **Sept. 2, 1949** and that death occurred at **2:00 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE H. M. Gilkey <i>H. M. Gilkey</i>	(Degree or title) M. D.	23b. ADDRESS 1624 Piny Bldg.	23c. DATE SIGNED
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 9-7-49	24c. NAME OF CEMETERY OR CREMATORY Mt. Calvary	24d. LOCATION (City, town, or county) (State) Kansas City, Kan.
DATE REC'D BY LOCAL REG. 9-5-49	REGISTRAR'S SIGNATURE Deraldine Holmes	25. FUNERAL DIRECTOR'S SIGNATURE B. C. Weikert ADDRESS K.C. 8, Mo.	

(Licensed Embalmer's Statement on Reverse Side)

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 _____

Blair E. W. W. W.

Signed.....
Student Embalmer

Licensed Embalmer No. _____

4075

P. O. Address _____

K. C. S. 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.