

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **37326**  
Registrar's No. **5196**

**FILED DEC 15 1951**

BIRTH NO. _____		REG. DIST. NO. <b>149</b>		PRIMARY REG. DIST. NO. <b>1002</b>		Registrar's No. <b>5196</b>	
1. PLACE OF DEATH a. COUNTY <b>Jackson</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Mo</b> b. CITY/TOWN <b>Jackson</b>			
b. CITY (If outside corporate limits, write RURAL and give township) <b>Kansas City</b>		c. LENGTH OF STAY (In this place) <b>1 week</b>		c. CITY (If outside corporate limits, write RURAL and give township) <b>Kansas City "Rural" 0489</b>		d. STREET ADDRESS (If rural, give location) <b>9627 E 9th</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Lakeside Osteo Hosp</b>				d. STREET ADDRESS (If rural, give location) <b>9627 E 9th</b>			
3. NAME OF DECEASED (Type or Print) <b>JOHN</b>		a. (First)		b. (Middle)		c. (Last) <b>GUNTER</b>	
4. DATE OF DEATH <b>12/3/51</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	
8. DATE OF BIRTH <b>11/28/k885</b>		9. AGE (In years last birthday) <b>66</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Operator</b>		11. BIRTHPLACE (State or foreign country) <b>Keetsville, Mo.</b>	
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY <b>Public Service</b>		11. BIRTHPLACE		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>William Gunter</b>		13b. MOTHER'S MAIDEN NAME <b>Hattie Lancaster</b>		14. NAME OF HUSBAND OR WIFE <b>Rose Gunter</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>486-10-1829</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. Rose Gunter, as above</b>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  <i>*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>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Pericarditis - Circulatory Collapse</i> ANTECEDENT CAUSES <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last...</i> DUE TO (b) <i>Acute myocardial infarction</i> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS: <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>				INTERVAL BETWEEN ONSET AND DEATH  <b>5411</b>	
19a. DATE OF OPERATION <b>11/26/51</b>		19b. MAJOR FINDINGS OF OPERATION <i>ruptured duodenum - Pericarditis - Coronary</i>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE <b>SUICIDE</b>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		21f. HOW DID INJURY OCCUR?	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		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 <b>11/12/51</b> , 19 <b>51</b> , to <b>12/2/51</b> , 19 <b>51</b> , that I last saw the deceased alive on <b>12/2/51</b> , 19 <b>51</b> , and that death occurred at <b>9:02</b> m., from the causes and on the date stated above.							
23a. SIGNATURE <i>Richard C. Sheil</i>				23b. ADDRESS <b>1009 1/2 W. James Blvd. Kansas City, Mo.</b>		23c. DATE SIGNED <b>12/4/51</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>12/7/51</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Mt. Washington</b>		24d. LOCATION (City, town, or county) (State) <b>Kansas City, Mo.</b>	
DATE REC'D BY LOCAL REG. <b>12-4-51</b>		REGISTRAR'S SIGNATURE <i>Geraldine Holmes</i>		25. FUNERAL DIRECTOR'S SIGNATURE <b>John P. Sheil, K. C. Mo.</b>		ADDRESS	

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.

Student .....  
Student Embalmer

Signed Richard C. Carroll

Licensed Embalmer No. 4829

P. O. Address K. 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.