

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

34984

State File No. _____

FILED NOV 8 1952
BIRTH NO. 50430

REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 4610

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. 19 days	c. CITY (If outside corporate limits, write RURAL and give township) a. TOWN Kansas City		
d. FULL NAME OF HOSPITAL OR INSTITUTION General Hospital No. 1			d. STREET ADDRESS (If rural, give location) 2805 Holmes		

438
5430

3. NAME OF DECEASED (Type or Print) a. (First) Daniel b. (Middle) H. c. (Last) Gast			4. DATE OF DEATH (Month) (Day) (Year) 10 19 52		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married	8. DATE OF BIRTH 7-30-52		9. AGE (In years last birthday) 2 IF UNDER 1 YEAR 19 MONTHS 19 DAYS 19 IF UNDER 12 HRS. 19 MIN.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Kansas City, Missouri		12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME George Gast		13b. MOTHER'S MAIDEN NAME Eulia Chulufas		14. NAME OF HUSBAND OR WIFE none	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mr. George Gast, 2805 Holmes, K.C., 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, asthenia, 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 appendicitis with rupture and abscess			rotation of
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		following surgery for correction of malrotation of gut with resultant volvulus of the ileum and intestinal obstruction			5703

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 Aug. 26, 19 52 to Oct. 19, 19 52 that I last saw the deceased alive on Oct. 19, 1952, and that death occurred at 1:20A m., from the causes and on the date stated above.

23a. SIGNATURE B.I. Burns, M.D. (Degree or title)		23b. ADDRESS 24th & Cherry		23c. DATE SIGNED 10-20-52	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 10-21-52	24c. NAME OF CEMETERY OR CREMATORY Calvary	24d. LOCATION (City, town, or county) (State) Kansas City, Missouri		
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DATE REC'D BY LOCAL REG. 10-22-52	REGISTRAR'S SIGNATURE Seraldine Smith		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Melody-McGilley-Eylar, Kansas City, Mo.		
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

De Tante

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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.....

.....
working under my personal supervision.

Signed.....
Student Embalmer

Signed.....

Student Embalmer No.....
JAR
Licensed Embalmer No. *2999*
P. O. Address *J.E. Ho*

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.