

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **14656**

FILED MAY 2 1953

BIRTH NO. _____ REG. DIST. NO. 150 PRIMARY REG. DIST. NO. 5572 Registrar's No. 2594

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 OR TOWN Rural Prairie	c. LENGTH OF STAY (If this place) 18 yrs.	c. CITY OR TOWN Independence 7005	
d. FULL NAME OF HOSPITAL OR INSTITUTION Jackson County Hospital		d. STREET ADDRESS (If rural, give location) 813 East Fair	

3. NAME OF DECEASED (Type or Print) a. (First) Mary	b. (Middle) Frances	c. (Last) Gallion	4. DATE OF DEATH (Month) (Day) (Year) April 12 1953
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 28 Jan 1882
9. AGE (In years last birthday) 71		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10. KIND OF BUSINESS OR INDUSTRY Housewife
11. BIRTHPLACE (City and State or Foreign Country) Ill.		12. CITIZEN OF WHAT COUNTRY? U.S.A./	

13a. FATHER'S NAME Melbern W. Randell	13b. MOTHER'S MAIDEN NAME Mary E. Young	14. NAME OF HUSBAND OR WIFE J. A. Gallion
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) No.	16. SOCIAL SECURITY NO. X X X	17. INFORMANT'S SIGNATURE OR NAME ADDRESS J.A. Gallion 813 E. Fair Indep., Mo.

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) Cause of death unknown		
ANTECEDENT CAUSES			
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) DUE TO (c)			
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	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) 7955
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Melbern W. Randell	23b. ADDRESS 4050 Bessolway Blvd	23c. DATE SIGNED 4-12-53
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 16 April	24c. NAME OF CEMETERY OR CREMATORY Floral Hills
DATE REC'D BY LOCAL REG. 4-21-53		24d. LOCATION (City, town, or county) (State) Kansas City, Mo.
REGISTRAR'S SIGNATURE D.B. Longford		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Floral Hills Memorial Chapels K. C.

(Licensed Embalmer's Statement on Reverse Side)

Mo.

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 _____

Lloyd C. McLeod

Licensed Embalmer No. 4853

P. O. Address R. 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.