

FILED JUL 9 - 1953

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **21486**  
**3003**

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. _____	
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) OR TOWN <u>Kansas City</u>		c. LENGTH OF STAY (In this place) <u>11 yrs.</u>		c. CITY OR TOWN <u>Kansas City</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Luke's Hospital</u>				e. STREET ADDRESS (If rural, give location) <u>3428 0</u>			
3. NAME OF DECEASED a. (First) <u>MRS. BERTHA</u> (Type or Print)			b. (Middle) <u>ANNA</u>		c. (Last) <u>BISHOP</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>6-12-53</u>
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>Wh</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Aug. 24, 1888</u>		9. AGE (In years last birthday) <u>64</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 10 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At home</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <u>New Hampton, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Jack Glutter</u>			13b. MOTHER'S MAIDEN NAME <u>Mary Fallis</u>		14. NAME OF HUSBAND OR WIFE <u>William E. Bishop</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>488-14-7978</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mr. Wm. Edward Bishop, 3040 Wayne, K.C. Mo.</u>			
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, asthma, etc. It means the disease, injury, or complication which caused death.</i>		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pulmonary Embolism</u>  ANTECEDENT CAUSES <u>Had radium insertion into uterus for ca</u> DUE TO (b) _____ DUE TO (c) _____				MEDICAL CERTIFICATION  INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>		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) _____	
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 <u>June 3, 1953</u> , to <u>June 13, 1953</u> , that I last saw the deceased alive on <u>June 10, 1953</u> , and that death occurred at <u>8:20 p.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>A. L. Spafford M.D.</u>				23b. ADDRESS <u>1414 Prof. Bldg. K.C. Mo.</u>		23c. DATE SIGNED <u>6-13-53</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>6-17-53</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u>		24d. LOCATION (City, town, or county) (State) <u>St. Joseph, Missouri</u>	
DATE REC'D BY LOCAL REG. <u>6-15-53</u>		REGISTRAR'S SIGNATURE <u>Geraldine Smith</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>STINE &amp; McCLURE K.C. MO.</u>			

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD  
A. L. Spafford M.D.

Dr. Allen Spofford  
1414 Prof. Bldg.  
Vi 1425  
after 10:30

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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.....  
Signature of Student Embalmer

Signed *Eugene J. ...*

Licensed Embalmer No... 4632

P. O. Address... H. C. ...

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.