

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **35870**
Registrar's No. **4850**

FILED OCT 28 1953

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002

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) 50 yrs	c. CITY OR TOWN Kansas City
d. FULL NAME OF HOSPITAL OR INSTITUTION General Hospital No. 1		e. STREET ADDRESS 2609 E. 12	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or Print) a. (First) Bessie	b. (Middle) May	c. (Last) Garrigan	4. DATE OF DEATH (Month) (Day) (Year) 10 7 1953
---	------------------------	---------------------------	---

5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2	8. DATE OF BIRTH Jan. 29, 1890	9. AGE (In years last birthday) 63	IF UNDER 1 YEAR Months	IF UNDER 2 HRS. Hours	IF UNDER 15 MIN. Min.
----------------------	-------------------------------	---	---------------------------------------	---	------------------------	-----------------------	-----------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (City and State or Foreign Country) Missouri 0	12. CITIZEN OF WHAT COUNTRY? USA
--	--	--	---

13a. FATHER'S NAME No Record	13b. MOTHER'S MAIDEN NAME No Record	14. NAME OF HUSBAND OR WIFE George P. Garrigan
-------------------------------------	--	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Mr. James C. Hyde, K.C. Missouri	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, ashenia, 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) Gastrointestinal hemorrhage		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Esophageal varices DUE TO (c) Cirrhosis of liver		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		Diabetes mellitus	5810

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) (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 Sept. 27, 1953, to Oct. 7, 1953, that I last saw the deceased alive on Oct. 7, 1953, and that death occurred at 11:20 A.M., from the causes and on the date stated above.

23a. SIGNATURE B. I. Burns (Degree or title) M.D.	23b. ADDRESS 24th & Cherry	23c. DATE SIGNED 10-8-53
---	---------------------------------------	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 10/9/53	24c. NAME OF CEMETERY OR CREMATORY Mt. Washington Cemetery	24d. LOCATION (City, town, or county) (State) Kansas City, Missouri
---	--------------------------	---	--

DATE REC'D BY LOCAL REG. 10-9-53	REGISTRAR'S SIGNATURE Geraldine Smith	25. FUNERAL DIRECTOR'S SIGNATURE Gates Funeral Home, K.C. Kansas	ADDRESS
---	--	---	---------

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

DL
11/12

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 *Jimmy S. Huckschorn*
Licensed Embalmer No. *4093*

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