

FILED SEP 24 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

30590

4150

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>Kansas</u> b. COUNTY <u>Wyandotte</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>18 weeks</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>				STREET ADDRESS (If rural, give location) <u>3813 Springfield</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>JULIA</u>		b. (Middle) <u>E.</u>		c. (Last) <u>GANTT</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Aug. 27, 1954</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>July 7, 1888</u>	
9. AGE (In years last birthday) <u>66</u>		IF UNDER 1 YEAR Months _____		IF UNDER 1 YEAR Days _____		IF UNDER 2 HRS. Hours _____	
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>Mississippi</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Thomas R. Byrn</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Lyons</u>		14. NAME OF HUSBAND OR WIFE <u>Irmon Gantt</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. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Otis Matthews, 3813 Springfield, K.C.Ks.</u>			
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Ventricular fibrillation</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Coronary occlusion</u> DUE TO (c) <u>Hypertensive C.V. disease</u>  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>3 min</u> <u>30 min</u> <u>15 yr</u> <u>4201</u>	
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) (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 <u>8-1-</u> , 19 <u>54</u> , to <u>8-27</u> , 19 <u>54</u> , that I last saw the deceased alive on <u>8-26-</u> , 19 <u>54</u> , and that death occurred at <u>7:10 p.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>R. B. HOLLISON</u> (Degree or title) _____				23b. ADDRESS <u>Med 3613 + 2nd</u>		23c. DATE SIGNED <u>8-28-54</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>8-30-54</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Forest Hill</u>		24d. LOCATION (City, town, or county) (State) <u>Kansas City, Missouri</u>	
DATE REC'D BY LOCAL REG. <u>8-30-54</u>		REGISTRAR'S SIGNATURE <u>Steraldine Smith</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>STINE &amp; McCLURE UND. CO.</u>		<u>K.C.MO.</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

6.300  
6.48

~~Dr. Herbert H. Johnson~~  
~~933 Bryant Bldg.~~  
~~W.A. 5778~~

Exp - 7:10 pm

Dr. Robert B. Johnson  
5829 Wagon Road  
Mission, Ks.  
Mo. 6460

35 48 1/2 Indiana  
over Meier's Drug Store

This afternoon

**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 *J. Crowell*.....

Licensed Embalmer No. *490*

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