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FILED JAN 28 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **1138**

BIRTH NO. _____ REG. DIST. NO. **149** PRIMARY REG. DIST. NO. **1002** Registrar No. **31**

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. CITY OR TOWN Kansas City	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (In this place) 18 yrs		STREET ADDRESS (If rural, give location) 1334 Central	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Luke's Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) MARGARET	b. (Middle) 2	c. (Last) GLOSSIP	4. DATE OF DEATH (Month) (Day) (Year) 1 4 55
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5. SEX F	6. COLOR OR RACE Wh	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Aug. 4, 1888	9. AGE (In years last birthday) 66	IF UNDER 1 YEAR Months	IF UNDER 12 HRS. Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during usual life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (City and State or Foreign Country) Plattsburg, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Dannie O'Connor	13b. MOTHER'S MAIDEN NAME Katherine Adams	14. NAME OF HUSBAND OR WIFE Matthew J. Glossip
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) xx	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Charley C. Glossip, 2616 Askew, KC 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) Abdominal mass - rt side, probably Ca. small bowel.		3 Mo.
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. ANOREXIA -		2 Mo.
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. cachexia, severe anaemia, 2 1/2 Mo. myocarditis, chronic, 2 1 Mo. passive congestion, 1 1/2 Mo.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION passive congestion, 1 1/2 Mo.	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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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?
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22. I hereby certify that I attended the deceased from **12/23/1954** to **1/4/1955**, that I last saw the deceased alive on **12/19/1955**, and that death occurred at **6:30 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE James Q. Chambers (Degree or title) M.D.	23b. ADDRESS 1103 Grand Ave	23c. DATE SIGNED 1/4/55
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24a. BURIAL CREMATION (REMOVED) (Specify) Burial	24b. DATE 1-4-55	24c. NAME OF CEMETERY OR CREMATORY Perrin Cemetery	24d. LOCATION (City, town, or county) (State) Perrin Mo.
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DATE REC'D BY LOCAL REG. 1-4-55	REGISTRAR'S SIGNATURE Neva Minshall	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Wagner Funeral Home K C Mo
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(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADEING 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.....
Signature of Student Embalmer

Signed *A. R. Hainschild*.....

Licensed Embalmer No. *415*.....

P. O. Address *R. E. I.*.....

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.