

FILED MAR 15 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 4807

643

BIRTH NO.		REG. DIST. NO. 149		PRIMARY REG. DIST. NO. 1202		Registrar's No.	
1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Kansas b. COUNTY Wyandotte			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		c. LENGTH OF STAY (in this place) 3 da		c. CITY OR TOWN Kansas City		d. If Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION. W H C side Hospital				e. STREET ADDRESS (If rural, give location) 1457 South 4th St F150 8			
3. NAME OF DECEASED (Type or Print) a. (First) Ralph			b. (Middle) Earl		c. (Last) Gingles Jr		4. DATE OF DEATH (Month) (Day) (Year) 2-11-55
5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) D		8. DATE OF BIRTH May 16-1954		9. AGE (In years last birthday) 8 25	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) California		12. CITIZEN OF WHAT COUNTRY? US
13a. FATHER'S NAME Ralph Gingles			13b. MOTHER'S MAIDEN NAME Barbara Huggins		14. NAME OF HUSBAND OR WIFE		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME Mr. Ralph Gingles Jr. 1457 South 4th St W H C Hospital		
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Acute right auricular dilation (b) Cerebellar abscess (c) acute bilateral bronchopneumonia DUE TO (b) (c) DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS upper respiratory infection Escherichia coli INTERVAL BETWEEN ONSET AND DEATH 590+					
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 Feb 5, 1955 to Feb 11, 1955, that I last saw the deceased alive on Feb 11, 1955, and that death occurred at 9:45 p. m., from the causes and on the date stated above.							
23a. SIGNATURE (Deputy or title) Richard C. Sheek DO				23b. ADDRESS 1100 1/2 Main St		23c. DATE SIGNED 2/12/55	
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE 2-14-55	24c. NAME OF CEMETERY OR CREMATORY Forest Hill Cemetery		24d. LOCATION (City, town, or county) (State) Kansas City MO		
DATE REC'D BY LOCAL REG 2-12-55		REGISTRAR'S SIGNATURE Neva Minshall			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Passatitrio Bros KCMO		

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD
Richard C. Sheek

2-11-32 04

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 *Leonard C. Passantini*

Licensed Embalmer No. *45*

P. O. Address *KC 7*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. 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.