

THE DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

FILED JAN 11 1956

State File No.

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 5530

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death.) a. STATE <u>Kansas</u> b. COUNTY <u>Wyandotte</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Kansas City</u>		c. LENGTH OF STAY (In this place) <u>4 days</u>	c. CITY OR TOWN <u>Kansas City</u>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St Marys Hospital</u>		STREET ADDRESS (If rural, give location) <u>2603 West 40th. St.</u> \$10 8	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Stanley</u> b. (Middle) <u>P.</u> c. (Last) <u>Gallen</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Dec. 18 1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>May 8, 1882</u>
9. AGE (In years last birthday) <u>74</u>		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Pennsylvania</u>
12. CITIZEN OF WHAT COUNTRY? <u>US</u>			

13a. FATHER'S NAME <u>No record</u>	13b. MOTHER'S MAIDEN NAME <u>No Record</u>	14. NAME OF HUSBAND OR WIFE <u>Alice Gallen</u>
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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>513-09-0651B</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Alice Gallen, K. C. Kansas</u>	ADDRESS
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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 <u>12/14/55</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage.</u>		
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Hypertension + arteriosclerosis (-?)</u> DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			<u>331X</u>

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	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)
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 12/14, 1955, to 12/18, 1955; that I last saw the deceased alive on 12/18, 1955, and that death occurred at _____ pm., from the causes and on the date stated above.

23a. SIGNATURE <u>Edson C. Carrier, M.D.</u> (Degree or title)	23b. ADDRESS <u>242 Plaza Med Bldg.</u>	23c. DATE SIGNED <u>12/19/55</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Dec. 21, 1955</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Forest Hill Cem.</u>	24d. LOCATION (City, town, or county) (State) <u>Kansas City, Missouri</u>
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DATE REC'D BY LOCAL REG. <u>12-20-55</u>	REGISTRAR'S SIGNATURE <u>Neva Marshall</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Gates Funeral Home, K. C. Kans.</u>	ADDRESS
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD
Edson C. Carrier

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 *Joseph M. M. Early*.....

Licensed Embalmer No. *4694*

P. O. Address *K C Mo*.....

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