

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **40567**  
**5159**  
Registrar No. \_\_\_\_\_

FILED DEC 28 1955

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **149** PRIMARY REG. DIST. NO. **1002**

|   |  |   |   |
|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Jackson</b>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <b>Missouri</b> b. COUNTY <b>Henry</b> |   |
| b. CITY (If outside corporate limits, write RURAL and give township) <b>Kansas City</b> |  | c. CITY OR TOWN <b>Montrose</b>   | d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| c. LENGTH OF STAY (in this place) <b>1 day</b>  |  | STREET ADDRESS (If rural, give location) <b>1 Mi West of Montrose</b>   |   |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St Joseph Hospital</b>                       |  |   |   |

|  |                             |                      |                         |   |
|--|-----------------------------|----------------------|-------------------------|---|
| 3. NAME OF DECEASED<br>(Type or Print) | a. (First) <b>Josephine</b> | b. (Middle) <b>-</b> | c. (Last) <b>Gerard</b> | 4. DATE OF DEATH<br>(Month) (Day) (Year)<br><b>11-28-1955</b> |
|--|-----------------------------|----------------------|-------------------------|---|

|                      |                               |   |                                   |   |   |   |
|----------------------|-------------------------------|---|-----------------------------------|---|---|---|
| 5. SEX <b>Female</b> | 6. COLOR OR RACE <b>White</b> | 7. MARRIED, NEVER MARRIED, / WIDOWED, DIVORCED (Specify) <b>married</b> | 8. DATE OF BIRTH <b>7-13-1883</b> | 9. AGE (In years last birthday) <b>72</b> | 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) <b>Housekeeper</b> | 10b. KIND OF BUSINESS OR INDUSTRY _____ | 11. BIRTHPLACE (City and State or Foreign Country) <b>Montrose Mo</b> | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b> |
|--|---|---|--|

|  |   |  |
|--|---|--|
| 13a. FATHER'S NAME <b>Bernard Blomet</b> | 13b. MOTHER'S MAIDEN NAME <b>Rose Stahl</b> | 14. NAME OF HUSBAND OR WIFE <b>John Gerard</b> |
|--|---|--|

|   |                                     |  |                            |
|---|-------------------------------------|--|----------------------------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> | 16. SOCIAL SECURITY NO. <b>none</b> | INFORMANT'S SIGNATURE OR NAME <b>John Gerard</b> | ADDRESS <b>Montrose Mo</b> |
|---|-------------------------------------|--|----------------------------|

|   |  |  |  |
|---|--|--|--|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asthenea, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION  |  | INTERVAL BETWEEN ONSET AND DEATH<br><br><b>42:1-</b> |
|   | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Acute Myocardial Infarction</b>  |  |  |
|   | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <b>Acute Coronary Thrombosis</b><br>DUE TO (c) _____ |  |  |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.   |  |  |  |

|                              |  |  |
|------------------------------|--|--|
| 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) _____ | 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 \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at \_\_\_\_\_ m., from the causes and on the date stated above.

|  |  |                                  |
|--|--|----------------------------------|
| 23a. SIGNATURE <b>H. Frank Hoban</b> (Degree or title) | 23b. ADDRESS <b>St Joseph Hospital</b> | 23c. DATE SIGNED <b>11-28-55</b> |
|--|--|----------------------------------|

|   |                           |   |  |
|---|---------------------------|---|--|
| 24a. BURIAL CREMATION (REMOVAL) (Specify) <b>Burial</b> | 24b. DATE <b>11-28-55</b> | 24c. NAME OF CEMETERY OR CREMATORY <b>Montrose Catholic</b> | 24d. LOCATION (City, town, or county) (State) <b>Montrose Mo</b> |
|---|---------------------------|---|--|

|  |  |   |                           |
|--|--|---|---------------------------|
| DATE REC'D BY LOCAL REG. <b>11-28-55</b> | REGISTRAR'S SIGNATURE <b>Neva Marshall</b> | 25. FUNERAL DIRECTOR'S SIGNATURE <b>Sickman &amp; Runnery</b> | ADDRESS <b>Clinton Mo</b> |
|--|--|---|---------------------------|

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY--USING UNFADING 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 *Robert L. Leman*.....

Licensed Embalmer No. *47*.....

P. O. Address *Clinton*.....

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.