

FILED JUL 5 1956

STANDARD CERTIFICATE OF DEATH

State File No. 20856

BIRTH NO. _____ REG. DIST. NO. 150 PRIMARY REG. DIST. NO. 5572 Registrar's No. 112

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) Rural Prairie		c. CITY (If outside corporate limits, write RURAL and give township) Independence	
c. LENGTH OF STAY (In this place) 3 Mo 1956		d. STREET ADDRESS (If rural, give location) 813 E. Fair	
d. FULL NAME OF HOSPITAL OR INSTITUTION JACKSON COUNTY Hosp		7005	
3. NAME OF DECEASED (Type or Print) a. (First) Jesse b. (Middle) Abraham c. (Last) Gallion		4. DATE OF DEATH (Month) (Day) (Year) JUNE 24 - 1956	
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH Jan-8-1878
9. AGE (In years last birthday) 78	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Molder	10b. KIND OF BUSINESS OR INDUSTRY Foundry	11. BIRTHPLACE (State or foreign country) Marshfield, Mo
12. CITIZEN OF WHAT COUNTRY? U.S.	13a. FATHER'S NAME Joseph Gallion	13b. MOTHER'S MAIDEN NAME Eliza A Ward	14. NAME OF HUSBAND OR WIFE Deceased - Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	16. SOCIAL SECURITY NO. NONE	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Josita M. Hall 813 E Fair	
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) Cerebral thrombosis ANTECEDENT CAUSES MORBID CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (a) STATING THE UNDERLYING CAUSE LAST. DUE TO (b) _____ DUE TO (c) ARTERIO Sclerosis	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 332x	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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 4-6 , 19 56 , to 6-24 , 19 56 , that I last saw the deceased alive on 6-22 , 19 56 and that death occurred at 12:30 m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) David W. Hoffman MD		23b. ADDRESS Johnson County	23c. DATE SIGNED 6-25
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 27 June 1956	24c. NAME OF CEMETERY OR CREMATORY Florence Hills	24d. LOCATION (City, town, or county) (State) Kansas City Mo.
DATE REC'D BY LOCAL REG. 6-25-1956	REGISTRAR'S SIGNATURE D. B. Langford	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Clonal Hill Memorial Chapel R.R. Mo.	

(Licensed Embalmer's Statement on Reverse Side)

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
Student Embalmer

Signed

Lloyd C McLeod

Licensed Embalmer No. 4853

P. O. Address

L. C. M.

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 this body is not embalmed, fact should be so stated above.