

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **26339**

S. No. 300
v. 10.48

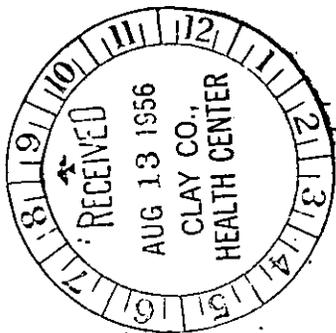
FILED AUG 20 1956

BIRTH NO. _____ REG. DIST. NO. **73** PRIMARY REG. DIST. NO. **5291** Registrar's No. **73**

1. PLACE OF DEATH a. COUNTY CLAY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MO b. COUNTY CLAY	
b. CITY OR TOWN Liberty-RURAL	c. LENGTH OF STAY (in this place) March 27-28	c. CITY OR TOWN Claytonia	d. Is residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION Odd-fellows Home		e. STREET ADDRESS (If rural, give location) 389 E. 69 Highway 600	
3. NAME OF DECEASED (Type or Print) EMMA	a. (First) EMMA	b. (Middle) F.	c. (Last) GALEY
5. SEX F	6. COLOR OR RACE W.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH June 10, 1860
9. AGE (In years last birthday) 95		if UNDER 1 YEAR Months 9	if UNDER 1 MRS. Hours 56
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (City and State or Foreign Country) West Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Samuel Whicker		13b. MOTHER'S MAIDEN NAME Betty E Spurgeon	
14. NAME OF HUSBAND OR WIFE deceased		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME Larence Galey	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Gum Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) _____ DUE TO (c) _____	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 4500	
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 <u>June 1956</u>, to <u>Aug 1, 1956</u>, that I last saw the deceased alive on <u>Aug 1, 1956</u> and that death occurred at <u>USA</u>, from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Wm. J. Goodson MD		23b. ADDRESS Liberty mo	
23c. DATE SIGNED 8/2/56		24a. BURIAL, CREMATION REMOVAL (Specify) Removal	
24b. DATE 8-4-56		24c. NAME OF CEMETERY OR CREMATORY ARKANSAS City Cem.	
24d. LOCATION (City, town, or county) (State) ARKANSAS City KAS.		25. FUNERAL DIRECTOR'S SIGNATURE D. W. Newcomer	
DATE REC'D BY LOCAL REG. 8-4-56		REGISTRAR'S SIGNATURE Mabel Graham	
ADDRESS 832 Armon Road		(Licensed Embalmer's Statement on Reverse Side)	

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

491-0



JUG 20 1956

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 *John Kalsbeck*

Licensed Embalmer No. *4949*

P. O. Address *No. Kansas City*

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.