

FILED AUG 29 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

27131

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2180

1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>				2. USUAL RESIDENCE (Where deceased lived. If institution) Residence before admission a. STATE <u>KANSAS</u> b. COUNTY <u>JOHNSON</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSAS CITY</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>PRAIRIE VILLAGE</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
d. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. MARY'S HOSPITAL</u>				Length of stay in hospital <u>26 yrs</u>		d. STREET ADDRESS (If outside, give location) <u>7305 WINDSOR</u>		
3. NAME OF DECEASED (Type or print) First <u>Gladys</u> Middle <u>M.</u> Last <u>SCHERER</u>				4. DATE OF DEATH <u>August 6, 1956</u> Month <u>August</u> Day <u>6</u> Year <u>1956</u>				
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 7, 1920</u>		9. AGE (In years last birthday) <u>36</u> IF UNDER 1 YEAR: Months <u>3</u> Days <u>6</u> Hours <u>15</u> Min. <u>5</u> IF UNDER 24 HRS. Hours <u>15</u> Min. <u>5</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>CINCINNATI, OHIO</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>ROBERT S. ARMACOST SR.</u>				14. MOTHER'S MAIDEN NAME <u>Viola Schnicke</u>				
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>493-22-7379</u>		17. INFORMANT <u>WILLIAM GORDON SCHERER SR.</u> Address <u>7305 WINDSOR PRAIRIE VILLAGE, KS</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Transverse Myelitis - spinal cord</u>							INTERVAL BETWEEN ONSET AND DEATH <u>14 days</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <u>0</u>		DUE TO (c) <u>0</u>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>None</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input type="checkbox"/>	HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>0</u>					
20c. TIME OF INJURY Hour <u>8:30</u> Month <u>8</u> Day <u>15</u> Year <u>1956</u> a. m. <u>p.</u> p. m.			20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <u>0</u>		20f. CITY, TOWN, OR LOCATION <u>0</u>		COUNTY <u>0</u>		STATE <u>0</u>		
21. I attended the deceased from <u>7/27/56</u> to <u>8/6/56</u> and last saw her/him alive on <u>8/6/56</u> Death occurred at <u>8:30 p.</u> 'm on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>Harold L. Gainey, M.D.</u>				22b. ADDRESS <u>4635 W. 24th St. Kansas City, Mo.</u>		22c. DATE SIGNED <u>8/7/56</u>		
23a. BURIAL, CREMATION, OR REMOVAL (Street/ly) <u>BURIAL</u>		23b. DATE <u>August 9, 1956</u>	23c. NAME OF CEMETERY OR CREMATOR <u>Mt. Olivet Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>KANSAS CITY, MISSOURI</u>			
24. FUNERAL DIRECTOR <u>D. W. NEWSOMER'S SONS</u> ADDRESS <u>1331 BRUSH CREEK BLVD</u>			25. DATE RECD. BY LOCAL REG. <u>8-8-56</u>		26. REGISTRAR'S SIGNATURE <u>Norm Minshall</u>			

(Licensed Embalmer's Statement on Reverse Side)

Health,  
Welfare  
Public  
Service300  
1-56

All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes. No symptoms will be listed. Doctor, coroner, etc. must use only standard nomenclature in item 18.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
Harold L. Gainey, M.D.

MEDICAL CERTIFICATION

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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 *Adrian Jay Still*.....

Licensed Embalmer No. *46*.....

P. O. Address *R.C., N.C.*.....

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.