

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33986

State File No.

FILED OCT 24 1956

4386

BIRTH NO.		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No.	
1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>		c. LENGTH OF STAY (In this place) <u>16 yrs.</u>		c. CITY OR TOWN <u>Kansas City</u>		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 <u>St Lukes Hospital</u>				e. STREET ADDRESS (If rural, give location) <u>850 1/2 W. 69 Th. St.</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Edna</u> b. (Middle) <u>M.</u> c. (Last) <u>Gilliland</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Oct. 8, 1956</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Dec. 19, 1885</u>		9. AGE (In years last birthday) <u>70</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>at Home</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) <u>Missouri</u>		12. CITIZENRY OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>James Medler</u>			13b. MOTHER'S MAIDEN NAME <u>Mary Fely</u>		14. NAME OF HUSBAND OR WIFE <u>Oliver S. Gilliland</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>none</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Dr. Oliver S. Gilliland</u> ADDRESS <u>K.C. Mo.</u>			
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>metastatic Carcinoma</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Carcinoma Fundus of uterus</u> DUE TO (c) <u>Reurrence after</u> <u>2 yrs</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>X-Ray + hysterectomy</u> <u>1 yr. ago</u>					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		172X			
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>July 19, 1956</u> to <u>Oct 8, 1956</u> that I last saw the deceased alive on <u>Oct 7, 1956</u> and that death occurred at <u>1230 P.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Don Carlos Peete M.D.</u>				23b. ADDRESS <u>1500 Prof. Bldg</u>		23c. DATE SIGNED <u>10-8-56</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		24b. DATE <u>10/10/56</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Newcomers Crematory</u>		24d. LOCATION (City, town, or county) (State) <u>Kansas City Mo.</u>		
DATE REC'D BY LOCAL REG. <u>10-9-56</u>		REGISTRAR'S SIGNATURE <u>Neva Minshall</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Stine & Mc Clure</u>		ADDRESS <u>Mo.</u>	

WRITE PLAINLY--USING UNFADING BLACK INK--MAKE A PERMANENT RECORD
Don Carlos Peete M.D.

Dr. Don Carlos Pate
Prof. Bldg. - Vi. 2-1145
2:30 till 5:30 Today

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..... *J. T. Crowell*
Licensed Embalmer No. *4904*

P. O. Address *J. T. Crowell*

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.