

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38021

State File No.

FILED DEC 7 - 1956

4991

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. <u>4991</u>	
1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Jackson</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>Kansas City</u>		c. LENGTH OF STAY (If in place) <u>1 1/2</u>		c. CITY OR TOWN <u>Kansas City</u>		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>Research Hosp</u>				e. STREET ADDRESS (If rural, give location) <u>1410 1016 Rocest</u>			
3. NAME OF DECEASED a. (First) <u>BERTRICE</u>			b. (Middle) _____		c. (Last) <u>GOWING</u>		4. DATE OF DEATH (Month) <u>11</u> (Day) <u>13</u> (Year) <u>56</u>
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widow</u>		8. DATE OF BIRTH <u>Jan 26, 1891</u>	
9. AGE (In years last birthday) <u>65</u>		IF UNDER 1 YEAR Months <u>9</u> Days <u>17</u>		IF UNDER 4 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>same</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Orick Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>ARTHUR SULLINGER</u>			13b. MOTHER'S MAIDEN NAME <u>MARTHA FRAZIER</u>		14. NAME OF HUSBAND OR WIFE <u>MASON GOWING</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>496-16-8992</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Maude Bowling Orick</u> ADDRESS <u>Orick 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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>congestive heart failure</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>coronary insufficiency</u> DUE TO (c) <u>coronary atherosclerosis</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>sclerosis</u>					INTERVAL BETWEEN ONSET AND DEATH <u>11/13</u>
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <u>no operation</u>			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 <u>Oct 15</u> , 19 <u>56</u> to <u>Nov 13</u> , 19 <u>56</u> that I last saw the deceased alive on <u>11/13</u> , 19 <u>56</u> , and that death occurred at _____ m., from the causes and on the date stated above.							
23a. SIGNATURE <u>Delon A. Williams M.D.</u> (Degree or title) _____				23b. ADDRESS <u>806 P. W. Bldg</u>		23c. DATE SIGNED <u>11/16/56</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>11-15-56</u>		24c. NAME OF CEMETERY OR CREMATORY <u>SOUTH POINT</u>		24d. LOCATION (City, town, or county) <u>Orick Mo.</u> (State) _____	
DATE REC'D BY LOCAL REG. <u>11-19-56</u>		REGISTRAR'S SIGNATURE <u>Reva Marshall</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>B W Good</u>		ADDRESS <u>Orick Mo.</u>	

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD
DeLON A. Williams

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.....
Charles F. Tyler

Licensed Embalmer No. 4534

P. O. Address.....
St. Louis, Mo.

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.