

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

5119

FILED MAR 7 1957

STATE FILE NUMBER

Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 77

1. PLACE OF DEATH a. COUNTY Jackson			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Jackson		
b. CITY (If outside corporate limits, give TOWNSHIP only) Independence		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Independence, Mo.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Kirby Rest Home Indep., Mo.		Length of stay in 1b 25yrs.	d. STREET ADDRESS 318 S. Osage		(If outside, give location) Residence on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Mrs. Eva Gabriel Clardy			4. DATE OF DEATH Feb. 25, 1957		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 1, 1865	9. AGE (In years last birthday) 91	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Fredrickstown, Mo.	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph P. Gabriel			14. MOTHER'S MAIDEN NAME Charnelcie Gabriel (unknown)		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. None	17. INFORMANT John G. Paxton 611 S. Liberty, Indep., Mo.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Encephalomalacia					INTERVAL BETWEEN ONSET AND DEATH months
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Hypertensive + arteriosclerotic Cardiovascular disease					years
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 443x					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.)			
20c. TIME OF INJURY Hour, Month, Day, Year a. m. 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.)	20f. CITY, TOWN, OR LOCATION		COUNTY STATE
21. I attended the deceased from 1945 to 2/25/57 and last saw her ^{her} him alive on 2/12/57 Death occurred at 12:15 p. m. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE Vance E. Link, M.D. Drs. Grabske & Link			22b. ADDRESS 10901 Winner, Indep., Mo.		22c. DATE SIGNED 2-26-57
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Feb. 27, 1957	23c. NAME OF CEMETERY OR CREMATORY Woodlawn		23d. LOCATION (City, town, or county) (State) Indep., Mo.	
24. FUNERAL DIRECTOR Ott & Mitchell		ADDRESS 310 N. Main Indep., Mo.		25. DATE RECD. BY LOCAL REG. 2-27-57	26. REGISTRAR'S SIGNATURE <i>James E. Link</i>

(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare, Public Service

300-1-56

All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

RECEIVED

RECEIVED

X

X

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 Henry J. Mitchell
Licensed Embalmer No. 392

P. O. Address L. d. M.

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.