

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

8014

STATE FILE NUMBER

FILED APR 15 1957

Registration District No. 72 Primary Registration District No. 4134 Registrar's No. 31

1. PLACE OF DEATH a. COUNTY <u>CLAY</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>CLAY</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>SMITHVILLE</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>6001 NORTH KANSAS CITY</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>COMMUNITY HOSPITAL</u>		Length of stay in 1b <u>2 weeks</u>	d. STREET ADDRESS (If outside, give location) <u>432 26th NORTH</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>ELIZA</u> Middle <u>ELLEN</u> Last <u>GABBERT</u>			4. DATE OF DEATH Month <u>APRIL</u> Day <u>1</u> Year <u>1957</u>		
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 22 1898</u>	9. AGE (In years last birthday) <u>58</u>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TELEPHONE OPERATOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>TELEPHONE CO</u>	11. BIRTHPLACE (City and state or country) <u>NEW MARKET, MO</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>CHARLES DOWNING</u>			14. MOTHER'S MAIDEN NAME <u>ELIZA BROWN</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>	17. INFORMANT <u>MISS NELLIE GABBERT</u> Address <u>ST. JOSEPH, MO</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>Coronary Occlusion</u> <u>Coronary artery sclerosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Sivertachitis - Calcifying (4201)</u>					INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part for 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 <u>1950</u> to <u>4/1/57</u> and last saw her <u>alive</u> on <u>4/1/57</u> Death occurred at <u>7:30 A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>H. S. Bowman M.D.</u>		22b. ADDRESS <u>Platte City, Mo</u>		22c. DATE SIGNED <u>4/1/57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removed</u>		23b. DATE <u>4/1/57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Joseph Mo.</u>		23d. LOCATION (City, town, or county) (State) <u>St. Joseph Mo</u>
24. FUNERAL DIRECTOR <u>Heaton-Bowman</u> ADDRESS <u>St. Joseph, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>4-1-57</u>		26. REGISTRAR'S SIGNATURE <u>Marquerite Hudgens</u>	

(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare, Public Service

300-56

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



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.....  
*Eugene Wood*

Licensed Embalmer No. 384

P. O. Address 314 So 10th St

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If  
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.