

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED APR 2 - 1957

STATE FILE NUMBER **8722**  
REGISTRAR'S NO. **1257**

Registration District No. **149** Primary Registration District No. **1002**

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>JACKSON</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSAS CITY</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>KANSAS CITY</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>3840 BELLEFONTAINE AVE - 45 YEARS</b>			Length of stay in <b>38</b>	d. STREET ADDRESS (If outside, give location) <b>3840 BELLEFONTAINE AVE</b>	
3. NAME OF DECEASED (Type or print) First <b>GERTRUDE</b> Middle <b>WOOD</b> Last <b>HULL</b>			4. DATE OF DEATH Month <b>3</b> Day <b>15</b> Year <b>1957</b>		
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY-15-1867</b>	9. AGE (In years last birthday) <b>89</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>AT HOME</b>		10b. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (City and state or country) <b>FARIBAULT MINNESOTA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13. FATHER'S NAME <b>GEORGE W. CHASE</b>			14. MOTHER'S MAIDEN NAME <b>ANNA D. WOOD</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	17. INFORMANT <b>MISS HELEN M. HULL</b> Address <b>3840 BELLEFONTAINE AVE KANSAS CITY, MO.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro-Vascular Accident</b>					INTERVAL BETWEEN ONSET AND DEATH <b>hours</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <b>Cerebral Arteriosclerosis</b>			years <b>301X</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) <b>Arteriosclerotic Heart Disease</b>					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 <b>3:40</b> Month <b>8</b> Day <b>9</b> Year <b>1956</b> a. m. <b>p. m.</b>					
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 <b>Aug 31 1956</b> , to <b>March 15 1957</b> and last saw <b>him</b> alive on <b>Dec 9 1956</b> Death occurred at <b>3:40 p m</b> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>John W. Cashman, MD</b> (Degree or title)			22b. ADDRESS <b>535 Argyle Bldg. KC Mo</b>		22c. DATE SIGNED <b>3/15/57</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>MAR 18 1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>FLORAL HILLS CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>KANSAS CITY MISSOURI</b>	
24. FUNERAL DIRECTOR <b>D.W. NEWCOMER'S SONS</b> ADDRESS <b>1331 BAYSH CREEK KANSAS CITY MO.</b>		25. DATE RECD. BY LOCAL REG. <b>3-18-57</b>	26. REGISTRAR'S SIGNATURE <b>Neva Minshall</b>		

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
John W. Cashman

alsh, Welfare Public Service  
000 -56  
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms with no diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

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 *E. L. Smith*.....  
Licensed Embalmer No. 50

P. O. Address K. 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.