

Health, & Welfare
Public
Service

STANDARD CERTIFICATE OF DEATH

17019
STATE FILE NUMBER
2065

FILED MAY 20 1957

Registration District No. 149 Primary Registration District No. 1002

Registrar's No. 2065

S. 300

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

MARY C. COLGLAZIER ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>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>4347 Benton Blvd</u>			Length of stay in lb <u>39 yrs</u>		d. STREET ADDRESS (If outside, give location) <u>4347 Benton Blvd</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>ELEANOR</u> Last <u>GIBBONS</u>				4. DATE OF DEATH Month <u>MAY</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 checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 7 1879</u>		9. AGE (In years last birthday) <u>70-71</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS. Min. <u>0</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (City and state or country) <u>Georgetown, Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13a. FATHER'S NAME <u>Robert D. McCubbin</u>			13b. MOTHER'S MAIDEN NAME <u>Catherine Frick</u>		14. NAME OF HUSBAND OR WIFE <u>Walter H. Gibbons</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>Home</u>		17. INFORMANT <u>Robert T. Gibbons, 6545 Edgewood Rd, K.C.</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>Cerebral Thrombosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hrs.</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Cerebral Arteriosclerosis</u>							DUE TO (c) <u>new yrs.</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Carcinoma of Colon - operated 2-3 wks ago</u>							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 checked="" 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>June 1956</u> to <u>May 1, 1957</u> and last saw her alive on <u>4/30/57</u> Death occurred at <u>638/A</u> on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>Mary C. Colglazier</u> (Name or title)					22b. ADDRESS <u>3317 E 43rd K.C. Mo.</u>			22c. DATE SIGNED <u>5-1-57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>5-4-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calvary</u>			23d. LOCATION (City, town, or county) <u>Seidalian, Mo.</u>		(State)	
24. FUNERAL DIRECTOR <u>Melody McSilly Elyar</u>			ADDRESS <u>K.C. Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>5-1-57</u>		26. REGISTRAR'S SIGNATURE <u>Neva Marshall</u>		

(Licensed Embalmer's Statement on Reverse Side)



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 *George J. Monahan*

Licensed Embalmer No. *4112*

P. O. Address *Riverside*

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.