

FILED JUN 24 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

20424

STATE FILE NUMBER

Registration District No. 73 Primary Registration District No. 5291 Registrar's No. 74

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>Jackson</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Liberty</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" 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>Odd Fellow Hospital</u>			Length of stay in lb <u>2 yrs</u>	d. STREET ADDRESS <u>unknown</u>			(If outside, give location) <u>3608</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Ora</u> Middle <u>Helen</u> Last <u>Galbreath</u>			4. DATE OF DEATH Month <u>June</u> Day <u>11</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"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 16, 1870</u>	9. AGE (In years last birthday) <u>87</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. Hours <u>0</u> 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		11. BIRTHPLACE (City and state or country) <u>Mt. Pleasant, Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>A. R. Morrison</u>				14. MOTHER'S MAIDEN NAME <u>Carrie M. Young</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.		17. INFORMANT <u>Hospital records</u> Address		
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>Paralytic Ca. Stomach</u> <u>(because of massive gastric Haem.)</u> DUE TO (b) <u>Arteriosclerosis with eva</u> DUE TO (c) <u>3 years</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</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 I or Part II of item 18.)				
20c. TIME OF INJURY Hour <u>a. m.</u> Month <u>July</u> Day <u>14</u> Year <u>1957</u> p. m.							
20d. INJURY OCCURRED WHILE AT <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 <u>Liberty Mo</u>		COUNTY STATE	
21. I attended the deceased from <u>July 7, 1957</u> to <u>July 14, 1957</u> and last saw her <u>alive</u> on <u>June 11, 1957</u> Death occurred at <u>7:30 p. m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>Wm. G. Gadsden</u> (Degree or title) <u>MD</u>				22b. ADDRESS <u>Liberty Mo</u>		22c. DATE SIGNED <u>9/11/57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>June 13, 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Forest Hill Cemetery</u>		23d. LOCATION (City, town, or county) <u>Kansas City Mo</u>		(State)	
24. FUNERAL DIRECTOR <u>Wagner Funeral Home, Kansas City Missouri</u> ADDRESS			25. DATE RECD. BY LOCAL REG. <u>6-14-57</u>		25. REGISTRAR'S SIGNATURE <u>Walter Graham</u>		

(Licensed Embalmer's Statement on Reverse Side)

Diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Health, Welfare, Public Service

800-56

71-2



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 P. T. H.*  
.....

Licensed Embalmer No. 45

P. O. Address *Lebanon*

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.