Health, & Welfare Public Service

S. 300
1-57

FILED AUG 7 1957

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

24981

STATE FILE NUMBER

Registration District No. 146 Primary Registration District No. 5568 Registrar's No. 330

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City [Blue] — Inside Limits Yes ☐ No ☒
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) 536 So. Hardy — Length of stay in 1b 15 yrs.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Jackson
c. CITY OR TOWN Kansas City [Blue] — Inside Limits Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location) 536 So. Hardy — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First NORA Middle FRANCES Last Gilchrist

4. DATE OF DEATH Month Day Year July-30-1957

5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH Nov-23-1873
9. AGE (In years last birthday) 83 — IF UNDER 1 YEAR Months — Days — IF UNDER 24 HRS. Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY At Home
11. BIRTHPLACE (City and state or country) Clifton Hill, Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME William Brockman
13b. MOTHER'S MAIDEN NAME Sarah Baker
14. NAME OF HUSBAND OR WIFE James Gilchrist

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. —
17. INFORMANT L. C. Gilchrist — Address 344 N. Belmont K.C. Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchial Pneumonia — INTERVAL BETWEEN ONSET AND DEATH 3 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Cerebral Hemorrhage — 1 week
DUE TO (c) Hemiplegia — 1 week
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Generalized Arteriosclerosis. 331X
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 1947, to July 29 and last saw her alive on 7/29/57
Death occurred at _____ on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Fred W. Hint M.D. (Degree or title)
22b. ADDRESS 10229 Judy Ave K.C. Mo
22c. DATE SIGNED 7-31-57

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE Aug. 1-1957
23c. NAME OF CEMETERY OR CREMATORY Clifton Hill Cemetery
23d. LOCATION (City, town, or county) Clifton Hill Mo. (State)

24. FUNERAL DIRECTOR C. H. Blackman & Son Inc. — ADDRESS K.C. Mo.
25. DATE RECD. BY LOCAL REG. 8-1-57
26. REGISTRAR'S SIGNATURE James S. Craig

(Licensed Embalmer's Statement on Reverse Side)

All diseases, in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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AUG 5 1957

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 W. C. Rinne

Licensed Embalmer No. 4879

P. O. Address K. C. Mo.

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.