

FILED SEP 24 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH31862  
STATE HEALTH BOARDRegistration District No. 149 Primary Registration District No. 1002 Registrar's No. 4082

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Michigan</b> b. COUNTY <b>Cass</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>Edwardsburg</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR <b>Warwick Nursing</b> INSTITUTION		Length of stay in 1b <b>7 Months</b>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>LENA</b> Middle <b>F.</b> Last <b>GALL</b>			4. DATE OF DEATH Month <b>Aug.</b> Day <b>29</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>11-11-1877</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	9. AGE (In years birthday) <b>79</b>
11. BIRTHPLACE (City and state or country) <b>Edwardsburg, Mich.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Uriah Arnold</b>		13b. MOTHER'S MAIDEN NAME <b>Phoebe Alexander</b>	14. NAME OF HUSBAND OR WIFE <b>Edward Gall</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 Address <b>Mrs. J. R. Swihart Leawood, Kansas</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>Uremia</b>			INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Hypertensive Cardiovascular Disease</b>			<b>7 years</b>
DUE TO (c) <b>Arteriosclerosis - Generalized</b>			<b>10 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Acute Spontaneous Inflammation left eye</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <b>4434</b>	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE 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>January 1956 to 8/29/57</b> and last saw her alive on <b>8/28/57</b> Death occurred at <b>5:35 P.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Name or title) <b>Russell M. Jones, M.D.</b>		22b. ADDRESS <b>4620 Nichols Pkwy</b>	22c. DATE SIGNED <b>8/30/57</b>
23a. BURIAL, CREMATION, REMOVAL <b>Removal</b>	23b. DATE <b>Aug. 30, 1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>-</b>	23d. LOCATION (City, town, or county) (State) <b>Cassopolis, Michigan</b>
24. FUNERAL DIRECTOR ADDRESS <b>Freeman Mortuary K.C.Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>9-1-57</b>	26. REGISTRAR'S SIGNATURE <b>Neva Marshall</b>

Florence E. Mac Iver, Registrar, Public Health Service, Missouri, St. Louis, Mo. All diseases in Part I must be causally related.

MEDICAL CERTIFICATION

*The Florence Mac Dennis  
4620 Franklin Ave  
Plymouth*

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 *J. P. Freeman* .....

Licensed Embalmer No. *2913*  
P. O. Address *F. O. M.*

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.