

FILED OCT 16 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

35812

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4542300 4  
1-57

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Jackson</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City, Mo.</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Kansas City, Mo.</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Grosse Nursing Home</b>		Length of stay in 1b <b>2 1/2 yrs.</b>	d. STREET ADDRESS <b>3918 3018 Charlotte</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Cora</b> Middle <b>L.</b> Last <b>Gabbert</b>			4. DATE OF DEATH Month <b>Sept</b> Day <b>30</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>3/23/1876</b>	9. AGE (In years last birthday) <b>81</b>	F UNDER 1 YEAR Months Days
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>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13a. FATHER'S NAME <b>Maion F. Wood.</b>		13b. MOTHER'S MAIDEN NAME <b>Octave Perkins</b>		14. NAME OF HUSBAND OR WIFE <b>I. Will Gabbert</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>No</b>	17. INFORMANT <b>Mrs. J. K. Marshall</b> <b>Daughter</b> <b>8711 E. 66th. terrace</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>Bronchial pneumonia</b>				INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Coronary heart failure</b>				<b>2 weeks</b>	
DUE TO (c) <b>arteriosclerotic heart disease</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>fractured hip right -</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 a.m. p.m. Month, Day, Year					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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>31 Dec 54</b> to <b>30 Sept 57</b> and last saw her alive on <b>29 Sept 57</b> Death occurred at <b>7 AM</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>Jack M. Davis M.D.</b> (Degree or title)			22b. ADDRESS <b>Raytown MO</b>		22c. DATE SIGNED <b>30 Sept 57</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>9/30/57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Ridge Park</b>		23d. LOCATION (City, town, or county) (State) <b>Marshall, Missouri</b>	
24. FUNERAL DIRECTOR <b>Stine &amp; McClure 3235 Gillham-K. C.</b>		ADDRESS	25. DATE RECD. BY LOCAL REG. <b>10-1-57</b>	26. REGISTRAR'S SIGNATURE <b>neva Marshall</b>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Jack M. Davis

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.



FILE 3-0100  
11:00 - 12:00  
1:00 - 5:00

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 *Elmo D. Triplett* .....

- Licensed Embalmer No. *4817* .....  
P. O. Address *Kansas City, 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.