

Health,
& Welfare
Public
Service

THE DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

35994

STATE FILE NUMBER

FILED OCT 24 1957

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4630

S. 300
1-57

All diseases in Part I must be causally related.

USE 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>KANSAS</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>Holtan</u> 815 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>St. Luke's Hosp</u> Length of stay in lb <u>2 DAYS</u>		d. STREET ADDRESS (If outside, give location) <u>226 PENNSYLVANIA</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Grace Violet Mac Gaffick</u>			4. DATE OF DEATH Month Day Year <u>10-5-57</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 9, 1904</u>
9. AGE (In years last birthday) <u>53</u>	10. 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>Circleville, Kansas</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	13a. FATHER'S NAME <u>Abner Voekel</u>	13b. MOTHER'S MAIDEN NAME <u>Gertrude</u>	14. NAME OF HUSBAND OR WIFE <u>Clyde Mac Gaffick</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>535-16-3677</u>	17. INFORMANT Address <u>Clyde Mac Gaffick, Mission Kan</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>Myocardial Infarction</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Coronary Thrombosis</u> DUE TO (c) <u>atherosclerotic coronary arteries</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> <u>1 hr.</u> <u>3 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4201</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 <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		COUNTY STATE	
21. I attended the deceased from <u>Aug 22 1957</u> to <u>Sept 5 57</u> and last saw her alive on <u>Sept 5 1957</u> Death occurred at <u>14:00 P.</u> m on the date stated above; and to the best of my knowledge, from the causes stated			
22a. SIGNATURE (Degree or title) <u>Bester Lee M.D.</u>		22b. ADDRESS <u>5830 Hall Mission Kansas</u>	
22c. DATE SIGNED <u>10-6-57</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>10-6-57</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>-</u>		23d. LOCATION (City, town, or county) (State) <u>Holtan, Kansas</u>	
24. FUNERAL DIRECTOR <u>Padden Mortuary, Holtan Kans</u>		25. DATE RECD. BY LOCAL REG. <u>10-6-57</u>	
ADDRESS		26. REGISTRAR'S SIGNATURE <u>vera minshall</u>	

(Licensed Embalmer's Statement on Reverse Side)

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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 *John R. Sidman*
Licensed Embalmer No. *4531*
P. O. Address *Kansas City*

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.