

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

40702  
STATE FILE NUMBER

FILED DEC 6 - 1957

Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 506

S. 300  
av. 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>Independence</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Independence</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Indep. Hosp.</b>		Length of stay in 1b <b>3 yrs.</b>	d. STREET ADDRESS <b>803 W. Truman Rd.</b>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>MISS NELL GAINES</b>			4. DATE OF DEATH <b>November 20, 1957</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 14, 1887</b>	9. AGE (In years last birthday) <b>70</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>X-Ray Technician &amp; Reg. Nurse</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Leavenworth, Ks.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13a. FATHER'S NAME <b>Dr. Noah Gaines</b>		13b. MOTHER'S MAIDEN NAME <b>Betty unknown</b>		14. NAME OF HUSBAND OR WIFE <b>--</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>495-05-8160A</b>		17. INFORMANT <b>Miss Nell Masters 803 W. Truman Indep. Mo.</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>Vasomotor collapse</b>				INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs.</b>	
Conditions, if any, which gave rise to above cause (a), stating the under- lying cause last.		DUE TO (b) <b>Distichial perforation tympanal membrane 2 yrs.</b>			
		DUE TO (c)			
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? <b>YES</b> <input type="checkbox"/> NO <input 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.					
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>1955</b> to <b>1957</b> and last saw her alive on <b>Nov. 20, 1957</b> Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>Paul Z Bachmann MD</b> (Degree or title)			22b. ADDRESS <b>Indep., Mo.</b>		22c. DATE SIGNED <b>11-22-57</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal November 23, 1957</b>		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY <b>Elmwood</b>		23d. LOCATION (City, town, or county) <b>Kansas City, Mo.</b> (State)
24. FUNERAL DIRECTOR <b>Ott &amp; Mitchell</b>		ADDRESS <b>Indep., Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>11-23-57</b>	26. REGISTRAR'S SIGNATURE <b>James Kelly</b>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

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.

54  
0

DEC 4 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 Jason White Licensed Embalmer No. 4925 P. O. Address ...

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.