

Dept. Health,
 & Welfare
 S. Public
 Health Service

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

44368
 STATE FILE NUMBER
 5612

FILED DEC 18 1957

Registration District No. 149 Primary Registration District No. 1002

Registrar's No. 5612

1. PLACE OF DEATH a. COUNTY JACKSON				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY JACKSON							
b. CITY (If outside corporate limits, give TOWNSHIP only) KANSAS CITY		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN 488 KANSAS CITY		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>					
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 121 EAST 8TH STREET			Length of stay in lb 15 YEARS		d. STREET ADDRESS (If outside, give location) 3531 WYANDOTTE ST.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First ALLEN Middle O. ORVEN Last GLORE				4. DATE OF DEATH Month NOV. Day 23 Year 1957							
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1895 DEC-6-1898		9. AGE (In years) 58 61	F UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OWNER & OPERATOR			10b. KIND OF BUSINESS OR INDUSTRY ALLIANCE OF GLOBE PRINTING & DIRECT MAIL		11. BIRTHPLACE (City and state or country) CHILLICOTHE, MO.		12. CITIZEN OF WHAT COUNTRY? U. S. A.				
13a. FATHER'S NAME Samuel GLORE			13b. MOTHER'S MAIDEN NAME DORA			14. NAME OF HUSBAND OR WIFE MRS. DAISY GLORE					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WORLD WAR I			16. SOCIAL SECURITY NO. -		17. INFORMANT Address MRS. DAISY GLORE 3531 WYANDOTTE STREET KANSAS CITY, MISSOURI						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Exhaustion asphyxiation & burns.								INTERVAL BETWEEN ONSET AND DEATH 8916 60			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost. DUE TO (b) _____ DUE TO (c) _____								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)											
20a. ACCIDENT <input checked="" 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.) In a building that exploded								
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year 11-23-57			20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> at 13th & burned								
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 13th & 13th			20f. CITY, TOWN, OR LOCATION KANSAS CITY			COUNTY JACKSON		STATE MO			
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ <input checked="" type="checkbox"/> Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE Hugh H. Owens					22b. ADDRESS 1034 Park Blvd			22c. DATE SIGNED 11-26-57			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town, or country) (State)				
BURIAL		NOV. 29 - 1957		CHILLICOTHE CEMETERY			CHILLICOTHE, MISSOURI				
24. FUNERAL DIRECTOR. D.W. NEWCOMER'S SONS					ADDRESS 1331 BRUSH CREEK KANSAS CITY MO.		25. DATE RECD. BY LOCAL REG. 11-27-57		26. REGISTRAR'S SIGNATURE Reva Minshall		

Doctor, coroner, etc.: must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part II must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Corrected by
A.S.S. 12/21/57
June 4, 1958 A.G.

Hugh H. Owens

KP
2

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 *Edward M. Storey*

Licensed Embalmer No. *4452*

P. O. Address *K. C. 10 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.