

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-014189  
STATE FILE NUMBER  
2055

FILED MAY 9 1958

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2055

1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</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>KANSAS CITY</u> 538
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. JOSEPH HOSPITAL</u>		Length of stay in lb <u>45 YEARS</u>	d. STREET ADDRESS (If outside, give location) <u>1207 ARMOUR BLVD</u>
3. NAME OF DECEASED (Type or print) First <u>SUSIE</u> Middle <u>E.</u> Last <u>GLEAVES</u>			4. DATE OF DEATH Month <u>April</u> Day <u>19</u> Year <u>1958</u>
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 30, 1885</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE AT HOME-DOMESTIC</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years on birthday) <u>73</u> IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> IF UNDER 24 HRS.: Hours <u>0</u> Min. <u>0</u>
11. BIRTHPLACE (City and state or country) <u>OAK GROVE, MISSOURI</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>JAMES R. LAND</u>		13b. MOTHER'S MAIDEN NAME <u>LETTIE SHROCK</u>	
14. NAME OF HUSBAND OR WIFE <u>HARRY T. GLEAVES</u>		Address <u>8727 HIGH DRIVE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>KENNETH L. GLEAVES</u>		Address <u>LEAWOOD, KANSAS</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>Fracture femur, intertrochanteric, left</u>			INTERVAL BETWEEN ONSET AND DEATH <u>59040</u> <u>21</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Diabetic mellitus,</u>			
DUE TO (c) <u>Uremia terminal</u>			
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? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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.) <u>Fell at home</u>	
20c. TIME OF INJURY Hour <u>4</u> a.m. <u>13</u> p.m. <u>58</u>			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>home</u>	
20f. CITY, TOWN, OR LOCATION <u>Kansas City, Missouri</u>		STATE <u>Missouri</u>	
21. I attended the deceased from <u>4-16-58</u> to <u>4-19-58</u> and last saw her alive on <u>4-19-58</u> Death occurred at <u>4-19-58</u> <u>7:10 P.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Garrett Pipkin M.D.</u> (Degree or title)		22b. ADDRESS <u>409 Argyle Bldg., Kansas City, Mo.</u>	
22c. DATE SIGNED <u>4-21-58</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>APR. 22-1958</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>MT. MORIAN CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>KANSAS CITY MISSOURI</u>	
24. FUNERAL DIRECTOR <u>D.W. NEWCOMER'S SONS</u> ADDRESS <u>1831 BRUSH CREEK R.C., MO</u>		25. DATE RECD. BY LOCAL REG. <u>4-22-58</u>	
26. REGISTRAR'S SIGNATURE <u>neva Minshall</u>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Nov 2-72 808

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 *Harold B. Eckert*

Licensed Embalmer No. 3035  
P. O. Address *H. B. Eckert*

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.