

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-032684

STATE FILE NUMBER

4128

FILED SEP 18 1958

Registration District No. 149 Primary Registration District No. 1002

Registrar's No.

300  
1-57

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) <u>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Kansas City</u> 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>2228 Duby</u>		Length of stay in lb <u>50 yrs</u>	d. STREET ADDRESS (If outside, give location) <u>2228 Duby</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Selbe</u> Last <u>Gift</u>			4. DATE OF DEATH Month <u>Aug</u> - Day <u>29</u> - Year <u>1958</u>
5. SEX <u>male</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>June 22 - 1891</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret - Country</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years) <u>66 1/2</u> IF UNDER 1 YEAR: Months <u>6</u> Days <u>17</u> Hours <u>0</u> Min. <u>0</u> IF UNDER 24 HRS.
11a. FATHER'S NAME (Foster) <u>C. A. Selbe</u>		11b. MOTHER'S MAIDEN NAME (Foster) <u>Wivy</u>	11c. BIRTHPLACE (City and state or country) <u>Missouri</u>
13a. FATHER'S NAME (Foster) <u>C. A. Selbe</u>		14. NAME OF HUSBAND OR WIFE <u>Jessie L. Gift</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>495-07-8293A</u>	17. INFORMANT <u>Jessie L. Gift</u> Address <u>K.P. Missouri</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>Acute Coronary Occlusion</u> DUE TO (b) <u>Hypertensive Cerebrovascular Disease</u> DUE TO (c) <u>U201</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>7 years</u> <u>4 years</u> <u>U201</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Prostate cancer - Acute Active Stomachal Ulcer</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 <u>1:15</u> Month <u>March</u> Day <u>54</u> Year <u>1958</u> a.m. <u>1:15</u> p.m.		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>March 54</u> to <u>8/29/58</u> and last saw him alive on <u>8/29/58</u> Death occurred at <u>1:15</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Paul A. Keubler MD</u>		22b. ADDRESS <u>5246 St. Bern</u>	
22c. DATE SIGNED <u>8/29/58</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Sept 2 - 58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mound Grove</u>	23d. LOCATION (City, town, or County) (State) <u>Independence Missouri</u>
24. FUNERAL DIRECTOR <u>R. Harold R. Speaks</u>		25. DATE RECD. BY LOCAL REG. <u>8-29-58</u>	26. REGISTRAR'S SIGNATURE <u>Neva Marshall</u>

MEDICAL CERTIFICATION  
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
Paul A. Keubler MD

All diseases in Part I must be causally related.



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 *Roland W. Sparks*

Licensed Embalmer No. *3604*

P. O. Address *Indep. 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.