

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-044116

STATE FILE NUMBER

JAN 14 1958 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 6179

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) OR TOWN KANSAS CITY		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN 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 620 EAST GREGORY		Length of stay in 1b 72 YEARS	d. STREET ADDRESS (If outside, give location) 620 EAST GREGORY BLVD		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last DENNIE WASHINGTON GIST			4. DATE OF DEATH Month Day Year DEC. 25, 1958		
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 FEB. 23, 1885	9. AGE (In years last birthday) 73	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MANUFACTURER		10b. KIND OF BUSINESS OR INDUSTRY CABINET CO. GIST	11. BIRTHPLACE (City and state or country) KANSAS CITY, KANSAS		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13a. FATHER'S NAME Leonidas GIST		13b. MOTHER'S MAIDEN NAME Effie Roberts		14. NAME OF HUSBAND OR WIFE HARRIET RENFRO GIST	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	17. INFORMANT Address CINCINNATI, OHIO MRS. J. MICHAEL McLELLAN		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) metastatic melanoma from left eye					INTERVAL BETWEEN ONSET AND DEATH 15 months
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					192*
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 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 1 August 1958 to 25 Dec 1958 and last saw her alive on 25 Dec 1958 Death occurred at 5:28 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) Blaine Z. Hubbard M.D.			22b. ADDRESS 411 Nichols AD KCMU		22c. DATE SIGNED 29 Dec 1958
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE Dec. 29, 1958	23c. NAME OF CEMETERY OR CREMATORY Mount St. Mary's		23d. LOCATION (City, town, or county) (State) KANSAS CITY, MISSOURI
24. FUNERAL DIRECTOR D.W. NEWCOMER'S SONS		ADDRESS 1331 BRUSH CREEK KANSAS CITY, MO.		25. DATE RECD. BY LOCAL REG. 12-29-58	26. REGISTRAR'S SIGNATURE new-minshall

All diseases in Part I must be causally related.

Blaine Z. Hubbard use ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

MAR 19 1959

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 *Vern Lueder*

Licensed Embalmer No. *4915*
P. O. Address *H.C. 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.