

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-013417

STATE FILE NUMBER

FILED APR 27 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1778

300
-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) 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>		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>2825 Olive</u>		Length of stay in lb <u>30 yrs</u>		d. STREET ADDRESS (If outside, give location) <u>2825 Olive</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Gordon</u> Last <u>McDonald</u>				4. DATE OF DEATH Month <u>April</u> Day <u>6</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</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>March 6, 1911</u>		9. AGE (In years last birthday) <u>48 yrs</u>	IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lithotype Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Printing</u>		11. BIRTHPLACE (City and state or country) <u>Little Rock, Ark</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13a. FATHER'S NAME <u>James Williams McDonald</u>			13b. MOTHER'S MAIDEN NAME <u>Edna Stewart</u>		14. NAME OF HUSBAND OR WIFE <u>Myra J. McDonald</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>482 25 7932</u>		17. INFORMANT Address <u>Joyce Roulette 2825 Olive K.C. Mo.</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>Shock</u>						INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Internal Abdominal Hemorrhage</u>							
DUE TO (c) <u>Penetrating Gunshot Wound of Abdomen.</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 checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>Gunshot wound</u>					
20c. TIME OF INJURY Hour <u>12:51</u> Month, Day, Year <u>4/6/1959</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>2825 Olive</u>		20f. CITY, TOWN, OR LOCATION <u>Kansas City</u>		20g. COUNTY <u>Jackson</u>	
20f. STATE <u>MO</u>							
21. I attended the deceased from _____ to _____ and last saw her or him alive on _____ Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>Deputy Coroner</u>				22b. ADDRESS <u>1618 Lydia Ave</u>		22c. DATE SIGNED <u>4/6/59</u>	
23a. BURIAL (CREMATION, REMOVAL (Specify)) <u>Burial</u>		23b. DATE <u>APR. 9, 1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Blue Ridge Lawn</u>		23d. LOCATION (City, town, or county) (State) <u>Kansas City, Missouri</u>	
24. FUNERAL DIRECTOR <u>Mrs. Meek's Mortuary K.C. Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>4-7-59</u>		26. REGISTRAR'S SIGNATURE <u>Neve Marshall</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

L. M. Tillman

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 *Millard B. Pasko*

Licensed Embalmer No. *5013*
P. O. Address *N. 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.