

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-013659

STATE FILE NUMBER

APR 28 1959 Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 175

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Jackson</b>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>                              |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br><b>Independence</b>                      |  | c. CITY OR TOWN <b>Independence</b> <sup>7005</sup>   |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>Indep. Hospital</b> |  | d. STREET ADDRESS (If outside, give location)<br><b>504 South Spring</b>  |  |
| Length of stay in 1b<br><b>1 yr.</b>  |  | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/><br>Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |  |

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|--|--|--|---|--|--|
| 3. NAME OF DECEASED (Type or print)<br>First <b>Nancy</b> Middle <b>Jean</b> Last <b>May</b> |  |  | 4. DATE OF DEATH <b>April 13, 1959</b><br>Month <b>April</b> Day <b>13</b> Year <b>1959</b> |  |  |
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|                      |                               |   |                                       |  |   |
|----------------------|-------------------------------|---|---------------------------------------|--|---|
| 5. SEX <b>Female</b> | 6. COLOR OR RACE <b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>Nov. 15, 1956</b> | 9. AGE (In years last birthday) <b>2</b> | IF UNDER 1 YEAR<br>Months <b>2</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b> |
|----------------------|-------------------------------|---|---------------------------------------|--|---|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>None</b> | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b> | 11. BIRTHPLACE (City and state or country)<br><b>Glenwood Spr. Colorado</b> | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b> |
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|   |   |  |
|---|---|--|
| 13a. FATHER'S NAME<br><b>Gilbert L. May</b> | 13b. MOTHER'S MAIDEN NAME<br><b>Marjorie A. Fry</b> | 14. NAME OF HUSBAND OR WIFE<br><b>None</b> |
|---|---|--|

|   |                                      |  |
|---|--------------------------------------|--|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b> | 16. SOCIAL SECURITY NO.<br><b>No</b> | 17. INFORMANT Address<br><b>Gilbert May Independence, Missouri</b> |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Sudden death during surgery for correction of fracture deformities of the femur</b> |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>7583</b>                        |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. }<br>DUE TO (c) <b>Osteogenesis Imperfecta</b>   |  |  |
| 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?<br><b>1 YES</b> NO <input 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.) |
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|--|---|--|---|
| 20c. TIME OF INJURY<br>Hour <b>10:00 A.</b> Month <b>Apr</b> Day <b>13</b> Year <b>1959</b><br>a.m. <b>0</b> p.m. <b>0</b> | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE 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 <b>Independence</b> COUNTY <b>Missouri</b> STATE <b>Missouri</b> |
|--|---|--|---|

21. I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_ and last saw her/him alive on \_\_\_\_\_  
Death occurred at **10:00 A.** m on the date stated above; and to the best of my knowledge, from the causes stated.

|   |   |                  |
|---|---|------------------|
| 22a. SIGNATURE (Degree or title)<br><b>James S. Bridges, M.D.</b> | 22b. ADDRESS<br><b>1509 W. Truman Rd. Independence, Mo. 17 Apr 59</b> | 22c. DATE SIGNED |
|---|---|------------------|

|  |                             |  |   |
|--|-----------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b> | 23b. DATE<br><b>4-15-59</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mound Grove</b> | 23d. LOCATION (City, town, or county) (State)<br><b>Independence Missouri</b> |
|--|-----------------------------|--|---|

|   |                             |  |  |
|---|-----------------------------|--|--|
| 24. FUNERAL DIRECTOR<br><b>Roland R. Speaks</b> | ADDRESS<br><b>Indep. Mo</b> | 25. DATE RECD. BY LOCAL REG.<br><b>4-15-59</b> | 26. REGISTRAR'S SIGNATURE<br><b>James S. Bridges</b> |
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 R. [Signature]* .....

Licensed Embalmer No. *3604* .....  
P. O. Address *Indy Ind* .....

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.