

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-020706

FILED JUN 24 1959

Registration District No. 393

Primary Registration District No. 1009

STATE FILE NUMBER 2871  
Registrar's No.

1. PLACE OF DEATH a. COUNTY <b>CLAY</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>CLAY</b>		
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSAS CITY NORTH</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>KANSAS CITY NORTH</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>2312 Pence AVENUE</b>		Length of stay in 1b <b>16 YRS.</b>	d. STREET ADDRESS (If outside, give location) <b>2312 PENCE AVENUE</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>GILBERT D. FRANCE</b>			4. DATE OF DEATH Month <b>JUNE</b> Day <b>5</b> Year <b>1959</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>APRIL 19, 1885</b>	9. AGE (In years last birthday) <b>74</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CHASE HOTEL</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>DESK CLERK</b>	11. BIRTHPLACE (City and state or country) <b>ALBANY, NEW YORK</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13a. FATHER'S NAME <b>FRANKLIN H. FRANCE</b>		13b. MOTHER'S MAIDEN NAME <b>CARRIE M. IRELAND</b>		14. NAME OF HUSBAND OR WIFE <b>OPAL FRANCE</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>491-09-3165</b>		17. INFORMANT Address <b>MRS. KENNETH E. STEVENS 2312 PENCE AVE., K. C. NORTH</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro-vascular accident</b>					INTERVAL BETWEEN ONSET AND DEATH <b>Hours</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Arterio-sclerosis</b>					<b>Years</b>
DUE TO (c)					
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 a.m. p.m. Month, Day, Year					
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 <b>1955 6-5</b> to <b>1959</b> and last saw <b>him</b> alive on <b>5 June 1959</b> . Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>[Signature]</b> (Degree or title) <b>M.D.</b>			22b. ADDRESS <b>1806 First Ave. North Kansas City Mo</b>		22c. DATE SIGNED <b>6/6/59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>JUNE 8, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>WHITE CHAPEL MEMORIAL GRDNS. CLAY COUNTY,</b>		23d. LOCATION (City, town, or county) (State) <b>MISSOURI</b>
24. FUNERAL DIRECTOR ADDRESS <b>D. W. NEWCOMER'S SONS * No. K. C., Mo.</b>			25. DATE RECD. BY LOCAL REG. <b>6-6-59</b>	26. REGISTRAR'S SIGNATURE <b>neva Marshall</b>	

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

R. D. Dwyer

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 *John H. Kalsbeek* .....

Licensed Embalmer No. *4949* .....  
P. O. Address *No. Kansas* .....

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.