

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-029182

FILED VS SEP 1 1959

3983

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. 1002 Registrar's No. _____

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>		c. CITY OR TOWN <u>Kansas City</u>	
Length of stay in 1b <u>40 yrs</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>General Hospital</u>		d. STREET ADDRESS <u>806 Washington</u> (If outside, give location)	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>W</u> Last <u>McCullough</u>			4. DATE OF DEATH Month <u>8</u> Day <u>15</u> Year <u>59</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>3-13-1865</u>	9. AGE (last birthday) <u>94</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____

10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Ret. Bldg. Attendant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Grant Co. Ky.</u>		11. BIRTHPLACE (City and state or country) <u>U.S.A</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>	
13a. FATHER'S NAME <u>Unknown</u>			13b. MOTHER'S MAIDEN NAME <u>McCullough Mary Rouse</u>			14. NAME OF HUSBAND OR WIFE <u>Alice McCullough</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>None</u>		17. INFORMANT <u>Mrs Harvey Rentschler 1431 Collins</u>		Address <u>K.C. Mo.</u>	
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Broncho-pneumonia</u>			
DUE TO (b) <u>Cerebral Thrombosis and Arterio-sclerosis</u>			
DUE TO (c) _____			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> 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.)			
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.		Month, Day, Year					
20d. INJURY OCCURRED WHILE AT WORK <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 8-3-59 to 8-15-59 and last saw him alive on 8-15-59
Death occurred at 4:15 P on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Abraham Gelpin</u>		22b. ADDRESS <u>2400 Cherry</u>		22c. DATE SIGNED <u>8-17-59</u>	
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>8-18-1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Floral Hills Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Kansas City MO.</u>	
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24. FUNERAL DIRECTOR <u>Floral Hills Memorial Chapel Inc</u>		ADDRESS <u>KC Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>8-17-59</u>		26. REGISTRAR'S SIGNATURE <u>Reva Marshall</u>	
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DOCUMENT

BY AFFIDAVIT OF Abraham Gelpin, M.D. MEDICAL CERTIFICATION

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed

by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Forrest D. Bolden

Licensed Embalmer No. 4714

P. O. Address KCMU

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to sign 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.