

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-032349

FILED VS. OCT 7 1959 149

Primary Registration District No. 1002 Registrar's No.

4536

STATE FILE NUMBER

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>		Length of stay in 1b <u>13da</u>		c. CITY OR TOWN <u>Grandview</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>Lake side Hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>13118 Highway 71</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>James author Gardner</u>				4. DATE OF DEATH Month Day Year <u>Sept 17-1959</u>					
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</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>06/19-1881</u>	9. AGE (last birthday) <u>77 1/2</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>Saw Filer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>OWN SHOP</u>		11. BIRTHPLACE (City and state or country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>		
13a. FATHER'S NAME <u>Essac Gardner</u>			13b. MOTHER'S MAIDEN NAME <u>Mary-Jumwalt</u>			14. NAME OF HUSBAND OR WIFE <u>Ella Gardner</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>489-22-9397</u>		17. INFORMANT <u>Mrs Ella Gardner - GRANDVIEW Mo.</u> Address <u>13118 571 Hwy</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>Cerebral Thrombosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Nephro-sclerosis</u>									
DUE TO (c) <u>Arteriosclerosis</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I <u>acute Prostatitis</u>						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			
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 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 <u>1-2-56</u> to <u>9-17-59</u> and last saw him alive on <u>9-17-59</u> Death occurred at <u>8 20/P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.				22a. SIGNATURE (Degree or title) <u>R.L. West M.D.</u>		22b. ADDRESS <u>Grandview Mo</u>		22c. DATE SIGNED <u>9-18-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>9-19-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MT. MORIAN CEMETERY</u>		23d. LOCATION (City, town, or county) <u>KANSAS CITY Mo.</u>				
24. FUNERAL DIRECTOR <u>E.K. Geogrey Broome</u>			ADDRESS <u>Grandview Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>9-18-59</u>		26. REGISTRAR'S SIGNATURE <u>Mrs Marshall</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF R. L. West

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. _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *Sturhuf E. Eddar*

Licensed Embalmer No. 4911

P. O. Address *Grandview*

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.