

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-036194

FILED VS OCT 16 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4761 STATE FILE NUMBER

UNRECORDED

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> 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>3 yrs.</u>		c. CITY OR TOWN <u>Kansas City</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>General Hospital</u>			Include Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>3937 Terrace</u>			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Drawry</u> Middle <u>Lovin</u> Last <u>Gullick</u>				4. DATE OF DEATH Month <u>9</u> Day <u>29</u> Year <u>59</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>12 19 76</u>	9. AGE (last birthday) <u>82 yrs.</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>EUREKA SPRINGS ARK.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>LARKIN GULLICK</u>			13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			14. NAME OF HUSBAND OR WIFE <u>DELLA MAY</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 Address <u>MRS. GEORGE QUIGLEY 3937 TERRACE</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>Broncho- Pneumonia</u> DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH
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	
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 Month, Day, Year a.m. p.m.							
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>9-20-59</u> to <u>9-29-59</u> and last saw him <u>live on</u> <u>9-29-59</u> Death occurred at <u>5:25</u> <u>A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Abraham Gelperin M.D.</u>			22b. ADDRESS <u>2400 Cherry</u>			22c. DATE SIGNED <u>10-1-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>OCT 2, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>FOREST HILL CEM</u>		23d. LOCATION (City, town, or county) (State) <u>KANSAS CITY MO.</u>		
24. FUNERAL DIRECTOR ADDRESS <u>D. W. NEWCOMER'S SONS K. C. MO.</u>			25. DATE RECD. BY LOCAL REG. <u>10-2-59</u>	26. REGISTRAR'S SIGNATURE <u>Elva Marshall</u>			

DOCUMENT

BY AFFIDAVIT OF

Abraham Gelperin 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 me

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed Chester K. Brown

Licensed Embalmer No. 493

P. O. Address K.P.M.

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.