

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-040056

UNRECORDED

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5578

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Kansas</b> b. COUNTY <b>Ottawa</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>	Length of stay in 1b <b>21 yrs.</b>	c. CITY OR TOWN <b>Minneapolis</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>Trinity Lutheran Hosp.</b>		d. STREET ADDRESS (If outside, give location)	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Hattie</b> Middle <b>G.</b> Last <b>Gard</b>			4. DATE OF DEATH Month <b>Nov.</b> Day <b>18,</b> Year <b>1959</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 24-1872</b>	9. AGE (last birthday) <b>87</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>At Home</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Metropolis, Illinois</b>	12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>
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13a. FATHER'S NAME <b>John F. Walbright</b>	13b. MOTHER'S MAIDEN NAME <b>Elizabeth Hughes</b>	14. NAME OF HUSBAND OR WIFE <b>William B. Gard</b>
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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>None</b>	17. INFORMANT Address <b>Dr. Frank C. Gard, Tuscon, Ariz.</b>
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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: IMMEDIATE CAUSE (a) <b>Diabetic Acidosis (with coma)</b>		INTERVAL BETWEEN ONSET AND DEATH <b>36 hrs.</b>
DUE TO (b) <b>Precipitated by Right suppurative parotitis</b>		<b>48 hrs.</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) <b>Arteriosclerosis Brain disease due to generalized arteriosclerosis</b>	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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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.)
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20c. TIME OF INJURY Hour <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	Month, Day, Year
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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 <b>Minneapolis, Kansas</b>	COUNTY <b>Minneapolis, Kansas</b>	STATE
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21. I attended the deceased from **November 16, 1959** to **November 18, 1959** and last saw her/him alive on **November 17, 1959**  
Death occurred at **8:10 AM** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>W. H. Goodson, Jr.</i>	(Degree or title)	22b. ADDRESS <b>730 Professional Building Kansas City 6, Mo.</b>	22c. DATE SIGNED <b>November 18, 1959</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>11-19-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Highland</b>	23d. LOCATION (City, town, or county) (State) <b>Minneapolis, Kansas</b>
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24. FUNERAL DIRECTOR <b>Stine &amp; McClure, Kansas City, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>11-19-59</b>	26. REGISTRAR'S SIGNATURE <i>W. H. Goodson, Jr.</i>
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BY AFFIDAVIT OF H. GOODSON, JR., 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 \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Joe B. Yoder

Licensed Embalmer No. 4173

P. O. Address K.C. Mo.

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.