

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-002028

FILED VS FEB

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STATE FILE NUMBER

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

1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY Jackson									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Independence		Length of stay in lb 1 1/2 Yrs		c. CITY OR TOWN Independence		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Indep. Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 1401 Cedar		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First GERTRUDE Middle MAY Last GARNER				4. DATE OF DEATH Month 1 Day 28 Year 1960									
5. SEX Female		6. COLOR OR RACE White		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 9 27 83		9. AGE (last birthday) 76		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) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (City and state or country) Crane, Missouri			12. CITIZEN OF WHAT COUNTRY U. S. A					
13a. FATHER'S NAME James A. McCullah				13b. MOTHER'S MAIDEN NAME Idella Parks				14. NAME OF HUSBAND OR WIFE James H. Garner					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Address Indep. Mo Mr. James H. Garner 1401 Cedar							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema - (terminal)										INTERVAL BETWEEN ONSET AND DEATH 6-8 days			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Atherosclerotic cerebrovascular disease - Hypertension + multiple areas (small) of encephalomalacia										5+ years			
DUE TO (c) encephalomalacia													
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 checked="" 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 June 1946 to Jan 28-1960 and last saw her alive on Jan 28-1960 Death occurred at about 5:30 PM on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE R. D. Gardner (Degree or title)						22b. ADDRESS Independence, Mo.			22c. DATE SIGNED 1-28-60				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1-30-1960		23c. NAME OF CEMETERY OR CREMATORY Floral Hills			23d. LOCATION (City, town, or county) Kansas City Missouri (State)						
24. FUNERAL DIRECTOR Floral Hills Memorial Chapels, Inc ADDRESS				25. DATE RECD. BY LOCAL REG. 1-30-60		26. REGISTRAR'S SIGNATURE James H. Garner							

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

after 1:00 p.m. Monday
W.R.

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 Ernest O. Coldenow

Licensed Embalmer No. 4714

P. O. Address KC 200

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