

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JUN 20 1960

=60-022369

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 653 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Buchanan				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph			Length of stay in 1b 73 yrs.		c. CITY OR TOWN St. Joseph		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1313 North 10th St., Kirkman Rest Home			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 426 North 17th St.,		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Logan M. Gore, Sr.				4. DATE OF DEATH Month Day Year June 7, 1960			
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Apr. 29, 1882	9. AGE (last birthday) 78	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Ross-Frazier Supply Co. Louisville, Ky		11. BIRTHPLACE (City and state or country) U.S.A.		12. CITIZEN OF WHAT COUNTRY	
13a. FATHER'S NAME Joseph B. Gore			13b. MOTHER'S MAIDEN NAME Laura R. Rodgers		14. NAME OF HUSBAND OR WIFE Edith Grace Gore		
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. 491-09-0012		17. INFORMANT Address Logan M. Gore, St. Joseph, Missouri			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral hemorrhage</i> DUE TO (b) <i>Sclerosis of vessels</i> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>
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"/> N. <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.) <i>Became unable to swallow</i>					
20c. TIME OF INJURY Hour Month, Day, Year <i>11:55 p.m. June 7-69</i>		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.) <i>Kirkman rest home</i>		20f. CITY, TOWN, OR LOCATION COUNTY STATE <i>St Joe 1313 N 10 Buchanan MO</i>	
21. I attended the deceased from <i>breath body</i> and last saw her alive on <i>6-7-60</i> Death occurred at <i>11:55</i> P.m. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <i>S. E. Meluney M.D. Coronor</i>			22b. ADDRESS <i>214 Kirkpatrick St Joseph MO</i>		22c. DATE SIGNED <i>6-10-60</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>	23b. DATE <i>June 9, 1960</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Memorial Park Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>St. Joseph, Missouri</i>			
24. FUNERAL DIRECTOR <i>Wieschhoff-Harmon Inc.</i> <i>by [signature]</i>			25. DATE RECD. BY LOCAL REG. <i>June 14, 1960</i>		26. REGISTRAR'S SIGNATURE <i>Wm. Clark Goodell</i>		

DOCUMENT

S. E. Meluney M.D. MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 *[Handwritten Signature]*
Licensed Embalmer No. 467
P. O. Address St. Jose

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