

REGISTRATION DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-026868

FILED AUG 8 1960

149

Primary Registration District No. 1002

Registrar's No. 3798

STATE FILE NUMBER

| | | | | | | | | | |
|---|--|---|---|--|---|--|---|-------|--|
| 1. PLACE OF DEATH a. COUNTY Jackson | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Kansas b. COUNTY Wyandotte | | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City | | Length of stay in 1b Life | | c. CITY OR TOWN Kansas City | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Luke's Hospital | | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) 3124 S. 46 th St. | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) First Anna Middle Louise Last Gilmore | | | | 4. DATE OF DEATH Month July Day 22 Year 1960 | | | | | |
| 5. SEX F | 6. COLOR OR RACE W | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH 8/16/1959 | 9. AGE (last birthday) 0 | IF UNDER 1 YEAR Months 11 Days 6 | IF UNDER 24 HR Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant | | | 10b. KIND OF BUSINESS OR INDUSTRY At Home | | 11. BIRTHPLACE (City and state or country) Kansas City, Missouri | | 12. CITIZEN OF WHAT COUNTRY USA | | |
| 13a. FATHER'S NAME Jor Gilmore | | | 13b. MOTHER'S MAIDEN NAME Juanita L. Johnston | | | 14. NAME OF HUSBAND OR WIFE None | | | |
| 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 Joe Gilmore Address Kansas City, Kansas | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hydrocephalus | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | DUE TO (b) Arnold-Chiari malformation | | | | | Congenital | | |
| | | DUE TO (c) Myelomeningocele | | | | | congenital | | |
| 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 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 August 1959 to 22 July 60 and last saw her alive on 22 July 1960 Death occurred at 10:40 P. m. on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | |
| 22a. SIGNATURE (Degree or title) Fred D. Fowler, MD. | | | | 22b. ADDRESS 4706 Broadway, Kansas City 12, Mo. | | | 22c. DATE SIGNED 24 July 1960 | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 23b. DATE 7/23/1960 | 23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery | | 23d. LOCATION (City, town, or county) Johnson County, Kansas | | (State) | | |
| 24. FUNERAL DIRECTOR ADDRESS E. Paul Amos Shawnee, Kans. | | | | 25. DATE RECD. BY LOCAL REG. 7-23-60 | | 26. REGISTRAR'S SIGNATURE Neva Marshall | | | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Fred D. Fowler

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 
E. Paul Amos

Licensed Embalmer No. 4385
10901 Johnson
P. O. Address Shawnee, Kan
ME1-5566

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.