

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-030554

FILED VS SEP 6 1960 149

Registration District No. 1002 Primary Registration District No. 1002 Registrar's No. 4302 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>CLAY</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>KANSAS CITY</u>		Length of stay in 1b <u>12 DAYS</u>	c. CITY OR TOWN <u>CLAYCOMO</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>OSTEOPATHIC HOSP</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>226 E. PARK</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>HIRAM</u> Middle <u>GATLIN</u> Last <u>GATLIN</u>			4. DATE OF DEATH Month <u>AUG</u> Day <u>19</u> Year <u>1960</u>				
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>3-24-1885</u>	9. AGE (last birthday) <u>75</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>OWNER ROUND TOP GARAGE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RAWLINGS CO, KS</u>		11. BIRTHPLACE (City and state or country) <u>U.S.A</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>	
13a. FATHER'S NAME <u>Charles GATLIN</u>		13b. MOTHER'S MAIDEN NAME <u>Elizabeth Blow</u>		14. NAME OF HUSBAND OR WIFE <u>Edith GATLIN</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 <u>RAY TANNHILL</u> Address <u>1608 Palatone</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) Lobar pneumonia with respiratory failure, sepsis, cerebral thrombosis with embolism to brain and emboli to brain

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. Generalized atherosclerosis, coronary artery disease, myocardial infarction

DUE TO (b)

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not listed as terms of the disease condition given in PART I (a)

INTERVAL BETWEEN ONSET AND DEATH
 Yes No 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.) <u> </u>
20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. <u> </u>	Month, Day, Year <u> </u> <u> </u> <u> </u>	

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u> </u>	20f. CITY, TOWN, OR LOCATION <u> </u>	COUNTY <u> </u>	STATE <u> </u>
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21. I attended the deceased from 8-8/60 to 8/19/60 and last saw her/him alive on 8/19/60
Death occurred at 1:50 p.m. 8/19/60 on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Glover N. Gillum MD</u>		22b. ADDRESS <u>926 E-17th St</u>		22c. DATE SIGNED <u>8/22/60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Aug 22-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fairview Cem</u>	23d. LOCATION (City, town, or county) (State) <u>Liberty, Mo</u>	
24. FUNERAL DIRECTOR <u>D.W. Newcomer Sons NKC</u>		ADDRESS <u> </u>	25. DATE RECD. BY LOCAL REG. <u>8-22-60</u>	26. REGISTRAR'S SIGNATURE <u>H.L. Dwyer</u>

DOCUMENT

Glover N. Gillum MD

BY AFFIDAVIT OF

Dr. Billham
830 A.M. Man
Osteopathic Hosp.

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 John W. Sewick

Licensed Embalmer No. 4848

P. O. Address 5-6-17, Mo

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.