

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

1968-61-013740  
STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. \_\_\_\_\_

AMENDED

FILED MAY 8 1961

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>JOHNSON</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSAS CITY</b>	Length of stay in 1b <b>2 days</b>	c. CITY OR TOWN <b>OVERLAND PARK</b>	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>V A HOSPITAL</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS <b>8443 Glenwood</b>	Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>DORSEY</b> Middle <b>Harold</b> Last <b>GISH</b>	4. DATE OF DEATH Month <b>April</b> Day <b>19</b> Year <b>1961</b>
--	---

5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>6-30-16</b>	9. AGE (last birthday) <b>44</b>	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) <b>Pharmacist</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Pharmacy</b>	11. BIRTHPLACE (City and state or country) <b>Ft. Scott, Kansas</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
--	--	--	--

13a. FATHER'S NAME <b>Leo N. Gish</b>	13b. MOTHER'S MAIDEN NAME <b>Faye Mahan</b>	14. NAME OF HUSBAND OR WIFE <b>Mable I. Gish</b>
--	--	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes 8-2-43 to 1-21-46</b>	16. SOCIAL SECURITY NO. _____	17. INFORMANT <b>VA Hospital Official Records, K.C. Mo.</b>
--	-------------------------------	--

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>Carcinoma of lung</b>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (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)		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 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 <b>K.C. - VAH</b>	COUNTY _____ STATE _____
---	--	--	---	--------------------------

21. I attended the deceased from <b>4-17-61</b> to <b>4-19-61</b> and last saw <sup>her</sup> / <sub>him</sub> alive on _____ Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.
---

22a. SIGNATURE (Ink or type) <b>JOE MATTER, MD</b>	22b. ADDRESS <b>K.C. - VAH</b>	22c. DATE SIGNED <b>4-21-61</b>
---	-----------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>	23b. DATE <b>4-22-61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Johnson Co. Mem. Garden, Overland Pk. Kansas</b>	23d. LOCATION (City, town, or county) <b>Overland Pk. Kansas</b>
---	-----------------------------	---	---

24. FUNERAL DIRECTOR <b>Hoge Funeral Home, Overland Pk. Kn.</b>	25. DATE RECD. BY LOCAL REG. <b>4-21-61</b>	26. REGISTRAR'S SIGNATURE <b>Ruth Long</b>
--	--	---

(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

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 me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

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

Signed J. Rayer Hoge

Licensed Embalmer No. 3579

P. O. Address Cleveland, Pa.

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.