ISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

ATMENT OF PUBLIC HEALTH AND WELFARE

-61-036909
STATE FILE NUMBER

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5356

FILED NOV 13 1961

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City
Length of stay in 1b 3 Hrs.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Menorah Hospital
Inside Limits Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY Cass
c. CITY OR TOWN Pleasant Hill
Inside Limits Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location) 1½ Mi. West of town
Reside on Farm Yes ☒ No ☐

3. NAME OF DECEASED (Type or print) First John Middle A. Last Gammon
4. DATE OF DEATH Month Oct. Day 25, Year 1961
5. SEX Male
6. COLOR OR RACE White
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH 8/13/1894
9. AGE (last birthday) 67
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) Farmer
10b. KIND OF BUSINESS OR INDUSTRY Farm
11. BIRTHPLACE (City and state or country) Greenwood Mo.
12. CITIZEN OF WHAT COUNTRY U S A
13a. FATHER'S NAME John A. Gammon
13b. MOTHER'S MAIDEN NAME Hattie Consoliver
14. NAME OF HUSBAND OR WIFE ~~Deceased~~ Pearl
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. unknown
17. INFORMANT Mrs Mamie Miller Address Harrisonville Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarction
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH
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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 _____, to _____ and last saw her/him alive on _____
Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Hugh A. Owens (Degree or title) Coroner
22b. ADDRESS 152 Union Station
22c. DATE SIGNED 10-26-61

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal
23b. DATE 10/28/1961
23c. NAME OF CEMETERY OR CREMATORY Lee's Summit Cem.
23d. LOCATION (City, town, or county) (State) Lee's Summit Mo.
24. FUNERAL DIRECTOR Langsford Funeral Home ADDRESS Lee's Summit Mo.
25. DATE RECD. BY LOCAL REG. 10-27-61
26. REGISTRAR'S SIGNATURE Ruth Long
(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF Hugh Owens

DOCUMENT

INSTEAD OF

SHOULD READ

DATE AMENDED

ITEM NO.

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 N B Langford

Licensed Embalmer No. 3833

P. O. Address Lis Summit

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.