

# SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-044696

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 6583

AMENDED

**FILED JAN 15 1962**

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>JACKSON</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSAS CITY</u>		c. CITY OR TOWN <u>KANSAS CITY</u>	
Length of stay in 1b <u>5 YRS.</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>3424 WASHINGTON</u>		d. STREET ADDRESS (If outside, give location) <u>3424 WASHINGTON</u>	
Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>CHARLOTTE N.</u> Middle <u>GAMBLE</u> Last <u>GAMBLE</u>			4. DATE OF DEATH Month <u>DEC</u> Day <u>30</u> Year <u>1961</u>			
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5. SEX <u>FEMALE</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>4/25/1876</u>	9. AGE (last birthday) <u>85</u>	IF UNDER 1 YEAR Months <u>  </u> Days <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>AT HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>IOWA</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>	

13a. FATHER'S NAME <u>WILLIAM H. VERMILYEA</u>		13b. MOTHER'S MAIDEN NAME <u>PHOEBE J. CUNNINGHAM</u>		14. NAME OF HUSBAND OR WIFE <u>ADAMUS D. GAMBLE</u>	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		17. INFORMANT <u>Virginia Gamble Washington</u> Address <u>3424</u>			
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18. CAUSE OF DEATH (Enter only one cause per line for (b), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u>			INTERVAL BETWEEN ONSET AND DEATH <u>instant</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>coronary arteriosclerosis</u>			
DUE TO (c) _____			

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>chronic asthmatic bronchitis</u>		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	
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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.)	
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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
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21. I attended the deceased from <u>11/30/56</u> to <u>12/30/61</u> and last saw her alive on <u>8/9/61</u>		Death occurred at <u>11 30</u> <u>A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE <u>James R. McVay, M.D.</u> (Degree or title)		22b. ADDRESS <u>814 VFW BLDG.</u>		22c. DATE SIGNED <u>12/30/61</u>	
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		23b. DATE <u>12/30/1961</u>		23c. NAME OF CEMETERY OR CREMATORY _____		23d. LOCATION (City, town, or county) (State) <u>OSKALOOSA IOWA</u>	
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24. FUNERAL DIRECTOR <u>STINE + MCCLURE</u> ADDRESS <u>KANSAS CITY, Mo</u>		25. DATE RECD. BY LOCAL REG. <u>12-31-61</u>		26. REGISTRAR'S SIGNATURE <u>Ruth Long</u>	
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(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

INSIDE OF

ITEM NO. SHOULD READ

DOCUMENT

BY AFFIDAVIT OF James R. McVay MEDICAL CERTIFICATION

**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 Balan W Week

Licensed Embalmer No. 5078

P. O. Address KC, Mo

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.