

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-001671

STATE FILE NUMBER

AMENDED

Registration District No. **149** Primary Registration District No. **1002** Registrar's No. **207**

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY PLATTE	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		Length of stay in lb 1 DAY	c. CITY OR TOWN PARKVILLE Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1447 E. 78th		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Box 286 Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last MARJORIE E. GALLUP			4. DATE OF DEATH Month Day Year 1 - 10 - 1962		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 8-29-1908	9. AGE (last birthday) 53	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) ST. PAUL, MINN.		12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME EDMOND MELLGREN		13b. MOTHER'S MAIDEN NAME FLORENCE BOXELL		14. NAME OF HUSBAND OR WIFE HULIS GALLUP	
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 Address HULIS GALLUP BOX 286 PARKVILLE, Mo.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE-CAUSE (a) **CORONARY HEART DISEASE 9 yrs**

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.
 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.)
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 **APR 1953** to **10 JAN 62** and last saw her/him alive on **27 DEC 61**
Death occurred at **100 P** m on the date stated above, and to the best of my knowledge from the causes stated.

22a. SIGNATURE (Dee or title) John F. McDonnell, M.D.	22b. ADDRESS 315 Nichols Road Kansas City	22c. DATE SIGNED 12 Jan 62 Mo.
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION	23b. DATE 1-13-1962	23c. NAME OF CEMETERY OR CREMATORY Newcomer's Crematory K.C.

24. FUNERAL DIRECTOR ADDRESS D.W. NEWCOMER'S SONS N.K.C., Mo.	25. DATE RECD. BY LOCAL REG. 1-13-62	26. REGISTRAR'S SIGNATURE Ruth Long
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(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 DATE AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 BY AFFIDAVIT OF
 JOHN F. MCDONNELL

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DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF
JOHN F. MCDONNELL

SHOULD READ

ITEM NO.

MAXWELL G. BERRY
PLAZA MED. BLDG.

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 John H. Kalsbeck

Licensed Embalmer No. 4949

P. O. Address W. Kansas City

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.