

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

9788

Registration District No. 399

Primary Registration District No. 1002

State File No.

Registrar's No. 1222

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Wesley Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1 Week  
(Specify whether  
In this community 49 Years  
years, months or days)

3. (a) PRINT FULL NAME Mrs. Grace R. Scott Gate 500

3. (b) If veteran, name war None 3. (c) Social Security No. 487\*01-804

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Mr. Albert E. Gate 6. (c) Age of husband or wife if alive 54 years

7. Birth date of deceased December 14 1890  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	49	3	1	hr. min.

9. Birthplace Kansas City Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Book Keeper

11. Industry or business Grand Avenue Garage

MOTHER FATHER { 12. Name William H. Scott

13. Birthplace Illinois  
(City, town, or county) (State or foreign country)

14. Maiden name Ravina L. Nash

15. Birthplace Illinois  
(City, town, or county) (State or foreign country)

18. (a) Informant Mrs. E. Maunden

(b) Address 3038 Garfield

17. (a) Burial (b) Date thereof March 21, 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Moriah Cemetery

18. (a) Signature of funeral director D. W. Newcomer's Sons

(b) Address 1401 Brush Creek Blvd.

19. (a) Mch 19, 1940 (b) M. Th. Crowe  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")

(d) Street No. 4416 Broadway  
(If rural, give location)

(e) If foreign born, how long in U. S. A.? ----- years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 15th  
year 1940 hour 5 minute P. M.

21. I hereby certify that I attended the deceased from Mar 13 1940 to Mar 15 1940  
that I last saw her alive on Mar 15 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death: Carcinoma of head of pancreas  
Laboratory reports  
Due to 46

Other conditions: Jaundice  
(Include pregnancy within 3 months of death)

Major findings: Carcinoma  
Of operations: Head of pancreas  
Of autopsy: no

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) no

(b) Date of occurrence no

(c) Where did injury occur? no  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? no

While at work? no (Specify type of place) (a) Means of injury no

23. Signature J. T. Mackley (M. D. or other)

Address Jefferson & 14th Date signed 3/16/40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

5381 Professional Bldg.  
10.3.38

**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.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed Emile M. Calhoun  
Licensed Embalmer No. 3506  
P. O. Address K. C. 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 this body is not embalmed, above space should be left blank.