

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Registration District No. **399** Primary Registration District No. **1002**

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: Research Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Unknown
In this community Unknown
years, months or days

3. (a) PRINT FULL NAME Mrs. Bertha Gaffney Orear.

3. (b) If veteran, name war NO. 3. (c) Social Security No. no.

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

6. (b) Name of husband or wife Edward S. Orear. 6. (c) Age of husband or wife if alive 49 years

7. Birth date of deceased March 16 1893
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
47 0 6 hr. min.

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

10. Usual occupation at home

11. Industry or business X

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant Edward S. Orear.
(b) Address 7426 Jefferson, Kansas City, Mo.

17. (a) Burial (b) Date thereof 3- -40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Moriah Cemetery.

18. (a) Signature of funeral director Stine & McClure.

(b) Address 3235 Gillham Plaza, K. C., Mo.

19. (a) Mch 22, 1940 (b) M. M. Brown
(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. 7426 Jefferson
(If rural, give location)
(e) If foreign born, how long in U. S. A. no. years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March, day 22nd
year 1940 hour 5:30 minute A. M.

21. I hereby certify that I attended the deceased from 1/16/40
19 to 3/21/40
that I last saw him alive on 3/21/40, 19
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia

Due to Chronic Gallbladder Disease with Stones

Due to 126

Other conditions Abscess retroperit.
(Include pregnancy within 3 months of death)

Major findings of operations enlarged colon, Gall stones, Fat necrosis
Of autopsy Confirming above

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

(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (2) Means of injury

23. Signature Edward Heller (M. D. or other)
Address 1010 Poplar Blv. Date signed 3/22/40

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

MOTHER FATHER

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

Dr. E. P. Heller,

AUG 3 1953

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.....

Licensed Embalmer No.....

P. O. Address.....

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.