V. S. No. 2
00M—2-43
Rev. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 6 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

1117

State File No.

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 340

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: St Joseph Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 10 days (Specify whether

In this community 57 yrs 0
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

(c) City or town Kansas City 8
(If outside city or town limits, write "RURAL")

(d) Street No. 920 Cherry
(If rural give location)

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Eleanor H. Gammon

3. (b) If veteran, name war no

3. (c) Social Security No. 491-20-6352

4. Sex Femal 1

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Paul Gammon

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Sept 16 1887
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
57	4	3	hr. min.

9. Birthplace Kansas City Mo 0
(City, town, or county) (State or foreign country)

10. Usual occupation Printing shop Operator

11. Industry or business Self

FATHER
12. Name John M. Dukes
13. Birthplace Illinois 1
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Mary
15. Birthplace Kansas 1
(City, town, or county) (State or foreign country)

16. (a) Informant Paul Gammon
(b) Address 920 Cherry

17. (a) Burial (b) Date thereof Jan 22 1945
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Forest Hill

18. (a) Signature of funeral director Mrs C R Fonter
(b) Address 918 Brooklyn

19. (a) 1-22-45 (b) D. E. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 19
year 1945 hour 4 minute P M.

21. I hereby certify that I attended the deceased from Jan. 9, 1945, to 1-19, 1945
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of Rectum c metastasis to Lungs & Liver

~~Due to~~

~~Due to~~ Post operative hemorrhage and shock

Other conditions 46 d
(Include pregnancy within 3 months of death)

Major findings:
Of operations Carcinoma of Rectum Dermoid cyst of Ovary; Fibroid Uterus Adenomyosis
Of autopsy As above

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)

(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?
(Specify type of place)

While at work? (e) Means of injury

23. Signature Marie Sherwood (M.D. ~~certifier~~)

Address Pathologist Date signed 1/20/45

(Licensed Embalmer's Statement on Reverse Side) St. Joseph Hospital, K.C.

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, fact should be so stated above.