

No. 2
M-5-43
5-17-39
I X36671

FILED MAY 27 1946
Registration District No. **749**

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: **General Hospital No. 1**
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **4 days**
(Specify whether years, months or days)
 In this community **4 days**

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **PLATE 83**
 (c) City or town **Parkville MO**
(If outside city or town limits, write "RURAL")
 (d) Street No. _____
(If rural, give location)
 (e) Citizen of foreign country? **NO** (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME **Iva Gallamore**
 3. (b) If veteran, name war **NO** 3. (c) Social Security No. **NO**

4. Sex **FEM** / 5. Color or race **WH**
 6. (a) Single, widowed, married, divorced **WID**
 6. (b) Name of husband or wife **UNK.** 6. (c) Age of husband or wife if alive **DEC** years
 7. Birth date of deceased **11/22/1888** **1878**
(Month) (Day) (Year)

8. AGE: Years **67** Months **5** Days **21**
 If less than one day hr. _____ min. _____

9. Birthplace **NEVADA, MO.**
(City, town, or county) (State or foreign country)
 10. Usual occupation **HOUSEWIFE**

MOTHER FATHER
 11. Industry or business _____
 12. Name **UNK.**
 13. Birthplace **UNK.**
(City, town, or county) (State or foreign country)
 14. Maiden name **UNK.**
 15. Birthplace **UNK.**
(City, town, or county) (State or foreign country)

16. (a) Informant **MRS JOSEPH MANNING**
 (b) Address **R #2, PARKVILLE, MO.**
 17. (a) **BURIAL** (b) Date thereof **5/15/46**
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **MEMORIAL PARK CEM.**
 18. (a) Signature of funeral director **JOHN P. SHEIL**
 (b) Address **N. C. MO**
 19. (a) **5-14-46** (b) **Geraldine Holmes**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **May** day **13**
 year **1946** hour **6** minute **20 A.M.**
 21. I hereby certify that I attended the deceased from **May 9**, 19**46**, to **May 13**, 19**46**;
 that I last saw her alive on **May 13**, 19**46**;
 and that death occurred on the date and hour stated above.

Immediate cause of death **Encephalomalacia-Bronchopneumonia**
 Due to _____
 Due to _____
 Other conditions **g3c**
(Include pregnancy within 3 months of death)

PHYSICIAN
 Major findings: _____
 Of operations _____
 Of autopsy **See 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?
(Specify type of place)

While at work? _____ (e) Means of injury **Car**
 23. Signature **Wm W Hart** (M. D. or M. P.)
 Address **Med. Dir. Gen'l Hosp.** Date signed **5-13-46**

15531
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

Dr. Williams

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.