No. 2
-1/47
17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
# STANDARD CERTIFICATE OF DEATH

State File No. 1092

FILED JAN 20 1949

Registration District No. ____ Primary Registration District No. 1002 Registrar's No. 117

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: OSTEOPATHIC HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 DAY (Specify whether
In this community 67 YEARS years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State: MISSOURI (b) County: JACKSON 48
(c) City or town: KANSAS CITY 3
(If outside city or town limits, write "RURAL")
(d) Street No.: 6115 SWOPE PARKWAY 8
(If rural, give location) 0
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country: ----

3. (a) PRINT FULL NAME: CORA. G. GIDINGHAGEN
3. (b) If veteran, name war: NO
3. (c) Social Security No.: NONE
4. Sex: FEMALE
5. Color or race: WHITE
6. (a) Single, widowed, married, divorced: MARRIED
6. (b) Name of husband or wife: WALTER G. GIDINGHAGEN MR.
6. (c) Age of husband or wife if alive: 81 years
7. Birth date of deceased: APRIL (Month) 21 (Day) 1875 (Year)

8. AGE: Years 72 Months 8 Days 16 If less than one day ____ hr. ____ min.

9. Birthplace: TERRE HAUTE (City, town, or county) INDIANA (State or foreign country)
10. Usual occupation: HOUSEWIFE - FORMER
11. Industry or business: PUBLIC SCHOOL TEACHER
MOTHER FATHER
12. Name: ROBERT CRAIG
13. Birthplace: UNKNOWN (City, town, or county) ARKANSAS (State or foreign country)
14. Maiden name: UNKNOWN
15. Birthplace: UNKNOWN (City, town, or county) (State or foreign country)
16. (a) Informant: Walter Gidinghagen
(b) Address: 6115 Swope Parkway
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JAN. 10 1948 (Month) (Day) (Year)
(c) Place: burial or cremation FOREST HILL CEMETERY
18. (a) Signature of funeral director: O. H. Newcomers Sons
(b) Address: 1401 - BRUSH CREEK BLVD.
19. (a) 1-9-48 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JAN day 7th year 1948 hour 11 minute 41 P. M.
21. I hereby certify that I attended the deceased from Feb 1936 to Jan 7 1948 that I last saw her alive on Jan 7 1948 and that death occurred on the date and hour stated above.

| Immediate cause of death | Duration |
|---|---|
| Chronic Myocarditis | about 3 yrs. |
| Due to | |
| Due to | |
| Other conditions (Include pregnancy within 3 months of death): Chronic Nephritis | |

Major findings:
Of operations: Paracentesis 15 ℔ ex cass fluid
Of autopsy: Congenital malformation in heart

PHYSICIAN — Underline the cause of 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 21

23. Signature: Elsie A. Erickson M. D. or other D.O.
Address: 4610 Troost Date signed Jan 8, 1948

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

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 D. E. Nofsinger

Licensed Embalmer No. 13938

P. O. Address Kansas City, M

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.