

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 23068
Registrar's No. 2870

FILED JUL 22 1948
Registration District No. 19

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:
K.C. General Hospital No. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 ds.
In this community 78 years
(Specify whether years, months or days)

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. 605 Cleveland
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME John H. Gill
3. (b) If veteran, name war None
3. (c) Social Security No. 499-09-1030

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month July day 11th
year 1948 hour 5 minute 15 A. M.

4. Sex Male 5. Color or race W.
6. (a) Single, widowed, married, divorced Div.
6. (b) Name of husband or wife Isabelle Gill
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased August 31, 1869
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 7-7-48 19____ to 7-11-48 19____
that I last saw her alive on 7-11-48 19____
and that death occurred on the date and hour stated above.

8. AGE: Years 78 Months 10 Days 10
If less than one day hr. _____ min. _____

Immediate cause of death Cerebral vascular accident
Duration _____

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

Due to _____
Due to _____

10. Usual occupation Stationary engineer

Other conditions _____
(Include pregnancy within 3 months of death)

11. Industry or business _____

MOTHER FATHER { 12. Name Daniel Gill
13. Birthplace Ireland
(City, town, or county) (State or foreign country)
14. Maiden name Ellen Schridner
15. Birthplace Iowa
(City, town, or county) (State or foreign country)

Major findings: 830
Of operations _____
Of autopsy None
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant John H. Gill Jr.
(b) Address 107 S. Wheeling

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____

17. (a) Burial (b) Date thereof 7-13-48
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Greenlawn Cem.

(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? _____

18. (a) Signature of funeral director Comp & Sons
(b) Address 1139 E. 15th
19. (a) 7-12-48 (b) Stearline Johnson
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place)
(c) Means of injury _____
23. Signature Wm W. Johnson (M. D. or other) _____
Dir. K.C. Gen. Hosp. _____
Address _____ Date signed _____

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

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.....

John B. Carp
.....

, Registered Apprentice No. *203*

working under my personal supervision.

Signed *John B. Carp*
.....

Licensed Embalmer No. *295-5*

P. O. Address *W.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, fact should be so stated above.