

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

LEB FEB 9 1952

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 373

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>	
c. LENGTH OF STAY (In this place) <u>50 yrs</u>		d. STREET ADDRESS (If rural, give location) <u>3615 West Roanoke Drive 34680</u>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>St. Luke's Hospital</u>			

3. NAME OF DECEASED (Type or Print)	a. (First) <u>NOEL</u>	b. (Middle) <u>F.</u>	c. (Last) <u>GILBIRDS</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Jan. 23, 1952</u>
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5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Sept. 22, 1873</u>	9. AGE (In years last birthday) <u>78</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 1 HR. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired-Adj. & Paymaster-Gas Serv. Co.</u>	10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (State or foreign country) <u>Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>John F. Gilbirds</u>	13b. MOTHER'S MAIDEN NAME <u>Marie Sauce</u>	14. NAME OF HUSBAND OR WIFE <u>Maude M. Gilbirds</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>487-10-9009</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Maude M. Gilbirds</u> KC Mo. ADDRESS <u>3615 W. Roanoke Dr.,</u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>33 hr</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Cerebral Sclerosis</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Kansas City Jackson Mo.</u>
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21d. TIME (Month) (Day) (Year) (Hour) OF INJURY _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR _____
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22. I hereby certify that I attended the deceased from Sept 15, 1946 to Jan 23, 1952, that I last saw the deceased alive on 1/22, 1952, and that death occurred at _____ m. (from the causes and on the date stated above).

23a. SIGNATURE <u>Richard L. Lehner MD</u> (Degree or title)	23b. ADDRESS <u>1102 Grand, Kansas City, Mo.</u>	23c. DATE SIGNED <u>1/23/52</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>1/25/52</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Floral Hills</u>	24d. LOCATION (City, town, or county) (State) <u>Kansas City, Missouri</u>
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DATE REC'D BY LOCAL REG. <u>1-24-52</u>	REGISTRAR'S SIGNATURE <u>Geraldine Halmea</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>STINE & McCLURE, Kansas City, Missouri</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Dr. Richard L. Linder
Bryant College
Oct. 29 1978

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed F. S. Walton

Licensed Embalmer No. 2744

P. O. Address R. E. MD

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.