

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 878

FILED MAR 8 1952
BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 878

1. PLACE OF DEATH a. COUNTY <u>JACKSON</u> 0		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> 368	
c. LENGTH OF STAY (In this place) <u>26 yrs</u>		d. STREET ADDRESS (If rural, give location) <u>5715 ST. JOHN AVE</u> 60	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>OSTEOPATHIC HOSPITAL</u>			

3. NAME OF DECEASED a. (First) <u>IRA</u> b. (Middle) <u>JAMES</u> c. (Last) <u>GIDDONS</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>FEB 24-1952</u>		
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>SINGLE</u> 0	
8. DATE OF BIRTH <u>JULY 26-1892</u>		9. AGE (In years last birthday) <u>77</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>REAL ESTATE BROKER REAL ESTATE</u>	
11. BIRTHPLACE (State or foreign country) <u>Ill</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>ROBERT GIDDONS</u>	
13b. MOTHER'S MAIDEN NAME <u>MARY ALICE JOHNSON</u>		14. NAME OF HUSBAND OR WIFE _____		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mr. John Kelly</u>		ADDRESS <u>H.C. Mc</u>	

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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Bronchial Pneumonia</u>			INTERVAL BETWEEN ONSET AND DEATH <u>15 1/2</u>
2. ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Left Hydronephrosis - Nephritis</u> DUE TO (c) <u>adenocarcinoma of sigmoid</u>		3. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Dehydration - Emaciation</u>			
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <u>Nodular mass in sigmoid involving bladder + blood</u>			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

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)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____	

22. I hereby certify that I attended the deceased from March 8, 1951, to Feb 24, 1952, that I last saw the deceased alive on Feb 23, 1952, and that death occurred at 9:30 A.M., from the causes and on the date stated above.

23a. SIGNATURE <u>James A. Di Renna</u> (Degree or title) <u>D.O.</u>		23b. ADDRESS <u>2603 Independence Ave</u>		23c. DATE SIGNED <u>2-24-52</u>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>FEB 27-52</u>		24c. NAME OF CEMETERY OR CREMATORY <u>MT WASHINGTON</u>	
24d. LOCATION (City, town, or county) <u>R.C. Mo</u>		24e. LOCATION (State) _____		DATE REC'D BY LOCAL REG. <u>2-25-52</u>	

REGISTRAR'S SIGNATURE <u>Deraldine Holmes</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. G. Shedd</u>		ADDRESS <u>H.C. Mc</u>	
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WRITE PLAINLY—USING 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.....

.....
working under my personal supervision.

Signed.....
Student Embalmer

Signed *John C. Smith*
Student Embalmer No.
Licensed Embalmer No. *3635*
P. O. Address *H.C. Mu*

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.