

THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 980

1. PLACE OF DEATH a. COUNTY Jackson 4		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo b. COUNTY Jackson 3776	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City	
c. LENGTH OF STAY (in this place) _____		d. STREET ADDRESS (If rural, give location) 4915 Montgall	
d. FULL NAME OF HOSPITAL OR INSTITUTION 3621 Warwick, Conv. Home			

3. NAME OF DECEASED a. (First) Viola		b. (Middle) M		c. (Last) Gillespie		4. DATE OF DEATH (Month) (Day) (Year) 2/29/52	
5. SEX Fem / Wh		6. COLOR OR RACE Wh		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Wid. 2		8. DATE OF BIRTH 7/2/1881	
9. AGE (In years last birthday) 70		IF UNDER 1 YEAR Months		IF UNDER 2 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) Unk.		12. CITIZEN OF WHAT COUNTRY? --	

13a. FATHER'S NAME John M. Robinson		13b. MOTHER'S MAIDEN NAME Alice Robinn		14. NAME OF HUSBAND OR WIFE Charles W. Gillespie	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. no		17. INFORMANT'S SIGNATURE OR NAME Mrs. Catherine Benjamin 87 & Hillcrest	

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.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CANCER OF UTERUS		INTERVAL BETWEEN ONSET AND DEATH 6 years	
ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. URINARY (PERIOD)		174X LUG	

19a. DATE OF OPERATION 0		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) 0		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) 0		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 302-66, 1938, to Feb 29, 1952, that I last saw the deceased alive on Feb 27, 1952, and that death occurred at 3 a. m., from the causes and on the date stated above.

23a. SIGNATURE P. C. Quistgard (Degree or title) M.D. MD		23b. ADDRESS 6200 Prospect (C.E. W)		23c. DATE SIGNED 3-1-52	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 3/3/52		24c. NAME OF CEMETERY OR CREMATORY St Marvys		24d. LOCATION (City, town, or county) (State) Kansas City, Mo.	
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DATE REC'D BY LOCAL REG 3-1-52		REGISTRAR'S SIGNATURE Geraldine Holmes		25. FUNERAL DIRECTOR'S SIGNATURE John P. Sheil, Kansas City, Mo.		ADDRESS	
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(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNEADING BLACK INK—MAKE A PERMANENT RECORD.

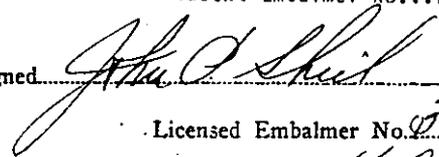
STATEMENT BY LICENSED EMBALMER

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.

Student Embalmer No.....

Signed



Signed.....
Student Embalmer

Licensed Embalmer No. 3625

P. O. Address K. 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.