

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **24804**  
Registrar's No. **3724**

BIRTH MO. **AUG 13 1953** REG. DIST. NO. **149** PRIMARY REG. DIST. NO. **1002**

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

|   |  |  |  |
|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Jackson</b>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <b>Mo.</b> b. COUNTY <b>Jackson</b> |  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Kansas City</b>   |  | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Kansas City</b>  |  |
| c. LENGTH OF STAY (in this place) <b>66 years</b>   |  | 3108   |  |
| d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>Woodland Nursing Home 512</b> |  | d. STREET ADDRESS (If rural, give location) <b>Woodland, Mo 512 Woodland</b>   |  |

|   |                             |                       |   |
|---|-----------------------------|-----------------------|---|
| 3. NAME OF DECEASED (Type or Print)<br>a. (First) <b>Emmett</b> | b. (Middle) <b>Clarence</b> | c. (Last) <b>Gale</b> | 4. DATE OF DEATH (Month) (Day) (Year)<br><b>July 26, 1953</b> |
|---|-----------------------------|-----------------------|---|

|                    |                               |  |                                      |   |                        |                       |                       |
|--------------------|-------------------------------|--|--------------------------------------|---|------------------------|-----------------------|-----------------------|
| 5. SEX <b>Male</b> | 6. COLOR OR RACE <b>White</b> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b> | 8. DATE OF BIRTH <b>June 1, 1887</b> | 9. AGE (In years last birthday) <b>66 years</b> | IF UNDER 1 YEAR Months | IF UNDER 24 HRS. Days | IF UNDER 1 MIN. Hours |
|--------------------|-------------------------------|--|--------------------------------------|---|------------------------|-----------------------|-----------------------|

|  |  |   |  |
|--|--|---|--|
| 10a. USUAL OCCUPATION (Give kind of work State or foreign name of occupation if retired) <b>Section Hand</b> | 10b. KIND OF BUSINESS OR INDUSTRY <b>Burlington R.A.</b> | 11. BIRTHPLACE (State or foreign country) <b>K.C. Mo.</b> | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b> |
|--|--|---|--|

|   |   |                             |
|---|---|-----------------------------|
| 13a. FATHER'S NAME <b>Francis R. Gale</b> | 13b. MOTHER'S MAIDEN NAME <b>Margaret Quinn</b> | 14. NAME OF HUSBAND OR WIFE |
|---|---|-----------------------------|

|   |  |  |
|---|--|--|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, unknown) <b>Yes</b> | 16. SOCIAL SECURITY NO. <b>486-12-9273</b> | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Mrs Mary House 3119 East 63rd St.</b> |
|---|--|--|

|   |   |  |                                  |
|---|---|--|----------------------------------|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*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 |
|   | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>atherosclerosis</b>   |  | <b>2 1/2</b>                     |
|   | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br><b>Arterio sclerosis</b><br>DUE TO (b)<br>DUE TO (c) |  | <b>2 1/2</b>                     |
| II. OTHER SIGNIFICANT CONDITIONS:<br>Conditions contributing to the death but not related to the disease or condition causing death.  |   |  | <b>45<sup>00</sup></b>           |

|                        |                                  |   |
|------------------------|----------------------------------|---|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES <input 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) m. | 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 **1-5-53**, 19**53**, to **7-26-53**, 19**53**, that I last saw the deceased alive on **7-26-53**, 19**53**, and that death occurred at **2.05 P.M.** the causes and on the date stated above.

|   |                                      |                                 |
|---|--------------------------------------|---------------------------------|
| 23a. SIGNATURE <b>Frank Paul Lauren</b> | 23b. ADDRESS <b>428 S. White Ave</b> | 23c. DATE SIGNED <b>7-26-53</b> |
|---|--------------------------------------|---------------------------------|

|  |                                |  |   |
|--|--------------------------------|--|---|
| 24a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b> | 24b. DATE <b>July 28, 1953</b> | 24c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's</b> | 24d. LOCATION (City, town, or county) (State) <b>K.C. Mo.</b> |
|--|--------------------------------|--|---|

|   |   |  |
|---|---|--|
| DATE REC'D BY LOCAL REG. <b>7-28-53</b> | REGISTRAR'S SIGNATURE <b>Sheldine Smith</b> | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Mrs. E. Quirk 4316 Troost Ave.</b> |
|---|---|--|

**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. ....

Student .....  
Student Embalmer

Signed.....

Licensed Embalmer No. ....

P. O. Address.....

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.