

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

5229

FILED MAR 3 1955

State File No. _____
Registrar's No. 74

BIRTH NO. _____ REG. DIST. NO. 146 PRIMARY REG. DIST. NO. 3026

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 OR TOWN <u>Independence</u>	c. LENGTH OF STAY (in this place) <u>36 yrs</u>	c. CITY OR TOWN <u>Independence</u>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>119 W. Linden</u>		e. STREET ADDRESS (If rural, give location) <u>119 W. Linden 7005</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>GERTRUDE</u> b. (Middle) <u>M.</u> c. (Last) <u>WELLS</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 20, 1955</u>		
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Feb 16, 1878</u>	9. AGE (In years last birthday) <u>77</u>	If UNDER 1 YEAR Months _____ Days _____	If UNDER 2 Wks. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work demanding most of working life, or if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (City and State of Foreign Country) <u>Kansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
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13a. FATHER'S NAME <u>James Hunter</u>		13b. MOTHER'S MAIDEN NAME <u>Josephine Best</u>		14. NAME OF HUSBAND OR WIFE <u>James M. Wells</u>	
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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>James M. Wells</u> ADDRESS <u>119 W. Linden</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 OF INTERVAL BETWEEN ONSET AND DEATH		
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>METASTATIC CARCINOMA BRAIN</u>	DUE TO (b) <u>CARCINOMA OF RIGHT BREAST</u>		3 MONTHS
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.	DUE TO (c) <u>WIDE SPREAD METASTASIS</u>		6 YEARS
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 <u>170 X</u>		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) _____
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 AUG 6, 1953 to FEB 20, 1955, that I last saw the deceased alive on FEB. 10, 1955, and that death occurred at 9:20 A.M., from the causes and on the date stated above.

23a. SIGNATURE <u>Robert L. Ward, M.D.</u> (Degree or title)	23b. ADDRESS <u>4126 ST. JOHN</u>	23c. DATE SIGNED <u>2-21-55</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Feb 22, 1955</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cem</u>	24d. LOCATION (City, town, or county) (State) <u>Indep. Mo</u>
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DATE REC'D BY LOCAL REG. <u>2-22-55</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	354 FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>Indep Mo</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

MS
FEB 3 1933

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.....
Signature of Student Embalmer

Signed..... *William L. Kepley*
Licensed Embalmer No. 42

P. O. Address *Indep.*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.