FILED MAY 7 - 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 13136

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1941

Health, & Welfare Public Service

. 300
. 1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part 1 must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City — Inside Limits Yes X No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) 420 West 62nd Street — Length of stay in 1b 50 YRS.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Jackson
c. CITY OR TOWN Kansas City, 3848 — Inside Limits Yes X No ☐
d. STREET ADDRESS (If outside, give location) 420 West 62nd Street — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First ELLA Middle B. Last GLADISH
4. DATE OF DEATH Month April Day 22 Year 1957
5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH June 15 1871 ~~app. ea.~~
9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ~~unknown~~ at home
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country) Clarksdale, Ill ~~unknown~~
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Thomas Gladish
14. MOTHER'S MAIDEN NAME Anna A. Clark
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ND (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. ND.
17. INFORMANT Stine & McClure Address K.C. Mo.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cause of death unknown
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH 7955
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Christian Scientist
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒ 2

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from _____, to _____ and last saw her/him alive on _____
Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) H L Dwyer MD 5
22b. ADDRESS City Hall KC MO
22c. DATE SIGNED 4-23-57

23a. BURIAL, CREMATION, REMOVAL (Specify) ENTOMBMENT
23b. DATE 4-24-57
23c. NAME OF CEMETERY OR CREMATORY FOREST HILL PANTHEON
23d. LOCATION (City, town, or county) (State) K. C. Mo.

24. FUNERAL DIRECTOR ADDRESS Stine & McClure - Kansas City, Mo.
25. DATE RECD. BY LOCAL REG. 4-24-57
26. REGISTRAR'S SIGNATURE Neva Minshall

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION 6-13-57 H.L. Dwyer

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was emb

by me, or by ....., Student Embalmer No.....

working under my personal supervision.

Student.....
Signature of Student Embalmer

Signed Eugene [illegible]

Licensed Embalmer No. 463

P. O. Address [illegible]

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Fa
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.