

Health, Public Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

24548

STATE FILE NUMBER

FILED AUG 12 1957

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 3482

| | | | | | | | | |
|---|----------------------------------|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Jackson | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | c. CITY OR TOWN Kansas City | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Mary's Hospital | | | Length of stay in 1b 20 Years | d. STREET ADDRESS (If outside, give location) 218 1/2 Perry | | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Dallas Paul Middle Gammon Last Gammon | | | | 4. DATE OF DEATH Month July Day 23 Year 1957 | | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Feb. 16 - 1890 | | 9. AGE (In years last birthday) 67 | IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> | IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) President of | | | 10b. KIND OF BUSINESS OR INDUSTRY Print Craft Press | 11. BIRTHPLACE (City and state or country) Des Moines, Iowa | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13a. FATHER'S NAME Warren Gammon | | | 13b. MOTHER'S MAIDEN NAME Anna Pickett | | 14. NAME OF HUSBAND OR WIFE Helen Gammon | | | |
| 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. 497-34-4585 | 17. INFORMANT Address Helen Gammon, 2702 Perry | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Psychonephritis, Bilateral prostatic hypertrophy, chronic Diabetes Mellitus, severe keton | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 3 wks. 2 yrs. 3 1/2 yrs. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Cirrhosis hepatic, Laennec type; Malnutrition | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT SUICIDE HOMICIDE None <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) Gastric severe ulceration duodenum Hiatal Hernia, block | | | | | | |
| 20c. TIME OF INJURY Hour <input type="checkbox"/> Month, Day, Year a.m. <input type="checkbox"/> p.m. None | | 20d. PLACE OF INJURY (e.g., in or about home, factory, street, office bldg., etc.) None | | | | | | |
| 20d. INJURY OCCURRED WHILE AT WORK? <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 20e. CITY, TOWN, OR LOCATION None | | 20f. COUNTY None | | 20g. STATE None | | |
| 21. I attended the deceased from June 1954 to 7/23/57 and last saw him alive on 7/23/57 - Death occurred at 7/23/57 on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | | | | |
| 22a. SIGNATURE (Degree or title) Harold A. Budke | | | | 22b. ADDRESS 1019 ARBYLE Bldg | | 22c. DATE SIGNED 7/24/57 | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 7-26-1957 | 23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery | | 23d. LOCATION (City, town, or county) (State) Kansas City, Mo. | | | |
| 24. FUNERAL DIRECTOR ADDRESS Melody-McGilley-Eyler Funeral Home 1800 E. Linwood, K. C., Mo. | | | 25. DATE RECD. BY LOCAL REG. 7-24-57 | | 26. REGISTRAR'S SIGNATURE Neva Minshall | | | |

Harold A. Budke

MEDICAL CERTIFICATION

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

(Licensed Embalmer's Statement on Reverse Side)

A. N. F. B...
Argyll Bldg
Rosl-4060

11:30 a.

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 *James E. Hackleman*

Licensed Embalmer No. *4573*

P. O. Address *9/2 Mr.*

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Kp

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.