

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35818
STATE FILE NUMBER
4701
Registrar's No.

FILED NOV 1 1957

Registration District No. 149 Primary Registration District No. 1202

S. 300
1-57

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 Hosp.			Length of stay in 1b 6 yrs		d. STREET ADDRESS (If outside, give location) 3516 Summit		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First STEPHEN Middle GASSEN Last GASSEN				4. DATE OF DEATH Month October Day 10 Year 1957									
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 23, 1879		9. AGE (In years last birthday) 78		10. UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0		11. IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer				10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (City and state or country) Lafette Co., Mo.			12. CITIZEN OF WHAT COUNTRY? U. S. A.				
13a. FATHER'S NAME Herbert Gassen				13b. MOTHER'S MAIDEN NAME Elizabeth Bell				14. NAME OF HUSBAND OR WIFE None					
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. None		17. INFORMANT Address H. F. Gassen, Higginsville, 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) Cerebral Vasculer Accident										INTERVAL BETWEEN ONSET AND DEATH 24 hours			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Hypertensive Cardiovascular Disease										Years Years			
DUE TO (c) Arteriosclerotic Heart Disease										Years Years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4200										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)										
20c. TIME OF INJURY Hour 10:40 a.m. A.M. Month, Day, Year October 10, 1957													
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			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 May 18, 1957 to October 10, 1957 and last saw him/her alive on October 10, 1957 Death occurred at 10:40 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE Emery R. Calovich						22b. ADDRESS 4620 Nichols			22c. DATE SIGNED 10-11-57				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town, or county) (State)					
Burial			10-12-57		Immaculate Conception Cem.			Higginsville, Mo.					
24. FUNERAL DIRECTOR Melody-McGilley-Eylar Funeral Home				ADDRESS Higginsville, Mo.		25. DATE RECD. BY LOCAL REG. 10-11-57		26. REGISTRAR'S SIGNATURE Neal Marshall					
1800 E. Linwood						(Licensed Embalmer's Statement on Reverse Side)							

MEDICAL CERTIFICATION
Emery R. Calovich

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.



Dr. Colvitch
4620 J.C. Nicholas
Ls 1-6510

1:30-3:30 PM

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 George Jackson, Student Embalmer No. 558 working under my personal supervision.

Student George Jackson
Signature of Student Embalmer

Signed Arthur Eugene Hoover
Licensed Embalmer No. 4912
P. O. Address 122 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.