

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-001419

STATE FILE NUMBER

FILED JAN 28 1959

Registration District No. \_\_\_\_\_

149

Primary Registration District No. 1002

Registrar's No. \_\_\_\_\_

232

300  
1-57

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|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Jackson</u>  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u> |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>Kansas City</u>                |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   | c. CITY OR TOWN <u>Kansas City</u><br>422<br>Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                            |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>General Hospital</u> |  | Length of stay in lb<br><u>27 yrs.</u>   | d. STREET ADDRESS (If outside, give location)<br><u>1516 W 29th</u><br>Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

|  |                                  |   |   |  |  |
|--|----------------------------------|---|---|--|--|
| 3. NAME OF DECEASED (Type or print)<br>First <u>DOROTHY</u> Middle <u>JUNE</u> Last <u>McGAIN</u>              |                                  |   | 4. DATE OF DEATH<br>Month <u>1</u> Day <u>12</u> Year <u>59</u>       |  |  |
| 5. SEX<br><u>Female</u>  | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>6-12-31</u>                                    | 9. AGE (In years last birthday)<br><u>27</u> | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months _____ Days _____ Hours _____ Min. _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>WAITRESS</u> |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>-</u>   | 11. BIRTHPLACE (City and state or country)<br><u>KANSAS CITY, Mo.</u> |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U. S. A.</u>                                    |

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 13a. FATHER'S NAME<br><u>ROBERT E. McGAIN</u>  |  | 13b. MOTHER'S MAIDEN NAME<br><u>Edna Noland</u> |  | 14. NAME OF HUSBAND OR WIFE<br><u>None</u>                                    |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>No</u> |  | 16. SOCIAL SECURITY NO.<br><u>-</u>             |  | 17. INFORMANT Address<br><u>Mr. Robert E. McGain, 1516 W. 29th St. KC Mo.</u> |  |

|   |  |   |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Bilateral atelectasis</u>                     |  | INTERVAL BETWEEN ONSET AND DEATH  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____  |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><u>C. a. by cervix - recent hysterectomy</u> |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input 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<br>Hour _____ Month, Day, Year _____ a.m. _____ p.m.                                  |  |  |  |   |  |
| 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 <u>12-29-58</u> to <u>1-12-59</u> and last saw her alive on <u>1-12-59</u><br>Death occurred at <u>4:15 p.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated. |  |  |                                    |
| 22a. SIGNATURE (Degree or title)<br><u>Abraham Gelpin</u>  |  | 22b. ADDRESS<br><u>24th &amp; Cherry</u> | 22c. DATE SIGNED<br><u>1-13-59</u> |

|  |  |                             |  |  |  |
|--|--|-----------------------------|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u> |  | 23b. DATE<br><u>1-15-59</u> | 23c. NAME OF CEMETERY OR CREMATORY<br><u>ST. MARY'S Com.</u> |  | 23d. LOCATION (City, town, or county) (State)<br><u>Kansas City, Mo.</u> |
| 24. FUNERAL DIRECTOR<br><u>Melody - McGilley - EYLAR</u>   |  | ADDRESS <u>Lin. St.</u>     |  | 25. DATE RECD. BY LOCAL REG.<br><u>1-13-59</u> | 26. REGISTRAR'S SIGNATURE<br><u>Irene Marshall</u>                       |

All diseases in Part I must be causally related.

Abraham Gelpin, M.D. BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *John H. Peyori* .....

Licensed Embalmer No. *2999* .....

P. O. Address *NC 276* .....

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.