

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-017716

FILED JUN 9 1959

Registration District No.

149

Primary Registration District No.

1002

STATE FILE NUMBER

Registrar's No. 2425

300
1-57

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE KANSAS b. COUNTY Salina	
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 SALINA Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR DELORA REST HOME INSTITUTION 622 BENTON BLVD.		Length of stay in lb 1 YEAR	d. STREET ADDRESS (If outside, give location) 8150 438 SOUTH 8th. STREET 8 Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last HENRY GEHRKE			4. DATE OF DEATH Month Day Year MAY 12, 1959
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 MARCH 20, 1892
9. AGE (In years last birthday) 67		10. KIND OF BUSINESS OR INDUSTRY CHIROPRACTOR	11. BIRTHPLACE (City and state or country) DELPHOS, KANSAS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13a. FATHER'S NAME ALBERT GEHRKE		13b. MOTHER'S MAIDEN NAME TENA GESKE	14. NAME OF HUSBAND OR WIFE VERA GEHRKE
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) NONE		16. SOCIAL SECURITY NO. 298-42-5053	17. INFORMANT 438 So. 8th, Address STREET MRS. VERA GEHRKE-SALINA, KANSAS
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronchial Pneumonia</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <i>Long standing diabetes</i> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 260X			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <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.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK 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 <i>Delaware St</i> to <i>12th St</i> and last saw her alive on <i>May 12, 1959</i> Death occurred at <i>5:28 P.</i> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>James I. Ferguson MD</i> (Degree or title)		22b. ADDRESS <i>410 Bryant Bldg</i>	22c. DATE SIGNED <i>May 14 59</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION	23b. DATE MAY 16, 1959	23c. NAME OF CEMETERY OR CREMATORY D. W. NEWCOMER'S SONS	23d. LOCATION (City, town, or county) (State) KANSAS CITY, MISSOURI
24. FUNERAL DIRECTOR 1331 BRUSH ADDRESS CREEK BLVD. D. W. NEWCOMER'S SONS-KANSAS CITY, MO.		25. DATE RECD. BY LOCAL REG. 5-15-59	26. REGISTRAR'S SIGNATURE <i>Neve Minchell</i>

James T. Ferguson USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

22

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~~ *Not Embalmed*, Student Embalmer No.
working under my personal supervision.

Student
Signature of Student Embalmer

Signed *Kennan W. Peterson*

Licensed Embalmer No. *4889*

P. O. Address *N.C., 7/0*

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.

104