

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-015328

FILED VS. MAY 9 1960 149

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

2252

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY <i>Jackson</i>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Jackson</i>			
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <i>Kansas City Mo.</i>		Length of stay in 1b <i>5.5 yrs</i>		c. CITY OR TOWN <i>Kansas city MO</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>4510 Genesee</i>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <i>4510 Genesee</i>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <i>John</i> Middle <i>Thomas</i> Last <i>Gascoigne</i>				4. DATE OF DEATH Month <i>April</i> Day <i>22</i> Year <i>1960</i>			
5. SEX <i>male</i>		6. COLOR OR RACE <i>white</i>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <i>2-14-1879</i>	
				9. AGE (last birthday) <i>81</i>		IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Warehouseman</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Santa Fe R.R. Co. Leicester England</i>		11. BIRTHPLACE (City and state or country) <i>U. S. A.</i>	
13a. FATHER'S NAME <i>David Gascoigne</i>			13b. MOTHER'S MAIDEN NAME <i>Clara Bauer</i>			14. NAME OF HUSBAND OR WIFE <i>Flossie Gascoigne</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>			16. SOCIAL SECURITY NO. <i>-</i>		17. INFORMANT <i>Flossie Gascoigne</i>		Address <i>4510 Genesee</i>
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>Arteriosclerotic heart disease</i> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
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 _____ a.m. _____ p.m.		Month, Day, Year _____					
20d. INJURY OCCURRED WHILE AT WORK <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 _____ 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) <i>Arch of Owens Corner</i>				22b. ADDRESS <i>1034 Rialto Bldg</i>		22c. DATE SIGNED <i>4-22-60</i>	
23a. MURIAL REFERENCE, REMOVAL (Specify)		23b. DATE <i>4-23-60</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Forest Hill</i>		23d. LOCATION (City, town, or county) (State) <i>Kansas City Mo</i>	
24. FUNERAL DIRECTOR <i>France Warnall Funeral Home</i>				25. DATE RECD. BY LOCAL REG. <i>4-22-60</i>		26. REGISTRAR'S SIGNATURE <i>Neva Marshall</i>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF H. O. OWENS

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Russell M Fran

Licensed Embalmer No. 425

P. O. Address KC M

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.