

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

2809-61-021266
STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. _____

AMENDED

FILED JUN 21 1961

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		Length of stay in 1b 70 YEARS	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. MARYS HOSPITAL		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 4024 CLARK Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First LISETTE Middle ANN Last GAMAGE			4. DATE OF DEATH Month 6 Day 4 Year 1961			
5. SEX FEMALE	6. COLOR OR RACE CAUCASIAN	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3-7-81	9. AGE (last birthday) 80	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER-AT HOME		10b. KIND OF BUSINESS OR INDUSTRY DOMESTIC		11. BIRTHPLACE (City and state or country) BEARDSTOWN, ILL.		12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME WILLIAM HOESNER		13b. MOTHER'S MAIDEN NAME EMMA BENZ		14. NAME OF HUSBAND DECEASED GLEN GAMAGE		
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 MRS. ERIE GATES, 4216 W. 63RD, MISSION, 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) Congestive Heart Failure	INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerosis	
DUE TO (c)	

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.
 Yes No Unknown

19. WAS AUTOPSY PERFORMED? 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 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 **1960** to **6-4-61** and last saw her/him alive on **6-4-61**
Death occurred at **2:15 P.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Joseph M. Masucci M.D.		22b. ADDRESS 636 Argyle Bldg.		22c. DATE SIGNED 6-4-61
23a. BURIAL, CREATION, REMOVAL (Specify) BURIAL	23b. DATE JUNE 6, 1961	23c. NAME OF CEMETERY OR CREMATOR Forest Hill	23d. LOCATION (City, town, or county) (State) KANSAS CITY MISSOURI	
24. FUNERAL DIRECTOR ADDRESS D.W. NEWCOMER'S SONS KANSAS CITY, MO. 1331 BRUSH CR.		25. DATE RECD. BY LOCAL REG. 6-6-61	26. REGISTRAR'S SIGNATURE Ruth Long	

DATE AMENDED

INSTEAD OF

DOCUMENT

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

Joseph M. Masucci - 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 Chester K Brown

Licensed Embalmer No. 4931

P. O. Address L.P. MD

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.