

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

61-035959

STATE FILE NUMBER

AMENDED

Registration District No. **042**

Primary Registration District No. **1000**

Registrar's No. **1043**

FILED OCT 23 1961

| | | | | | | | | | | | | | |
|--|--|---|--|---|---|--|---|--|-------------------------------------|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Buchanan | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY Jackson | | | | | | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph, | | Length of stay in 1b 1hr | | 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 D.O.A. St. Joseph Hospital | | | Inside Limits No <input type="checkbox"/> | | d. STREET ADDRESS 1506 E Linnwood Blvd (If outside, give location) | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Clair Middle Franklin Last Gatton | | | | 4. DATE OF DEATH Month Oct. Day 10, Year 1961 | | | | | | | | | |
| 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 Dec 11, 1890 | | 9. AGE (last birthday) 70 | | 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) Re. Telegraph Op. | | | | 10b. KIND OF BUSINESS OR INDUSTRY Railroad | | 11. BIRTHPLACE (City and state or country) Leon Iowa | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | | | | | |
| 13a. FATHER'S NAME Isaac Gatton | | | | 13b. MOTHER'S MAIDEN NAME Mary Parson | | | | 14. NAME OF HUSBAND OR WIFE Mary Gatton | | | | | |
| 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. Unk | | 17. INFORMANT Address Mary Gatton, KC. Missouri | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Unattended Death - Apparently Natural Causes. | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | DUE TO (b) | | | | | | | | | | | |
| | | DUE TO (c) Investigated by City Health Department | | | | | | | | | | | |
| 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 checked="" 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 10/10/61 and last saw her/him alive on _____ Death occurred at 4:45 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | | | | | |
| 22a. SIGNATURE Robert W. Kieber, MD City Health Officer (Degree or title) | | | | | | 22b. ADDRESS St. Joseph, Mo | | | 22c. DATE SIGNED 10-16-61 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b. DATE 10/13/61 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery | | | 23d. LOCATION (City, town, or county) St. Joseph, Mo (State) | | | | | |
| 24. FUNERAL DIRECTOR John Rupp ADDRESS St. Joseph, Mo | | | | 25. DATE RECD. BY LOCAL REG. Oct. 19, 1961 | | | | 26. REGISTRAR'S SIGNATURE Mrs. Clark Standell | | | | | |

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

R.W. Kieber, MD

OCT 23 1961

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,

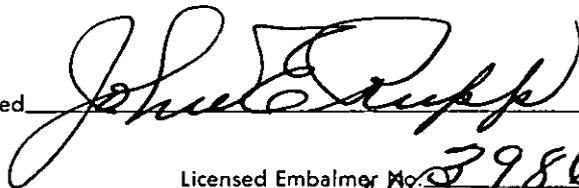
~~of~~ _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed _____



Licensed Embalmer No. 3986

P. O. Address H. Joseph

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.