

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH.
DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-024329

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 3158

FILED JUN 17 1963

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived) If institution: Residence before admission) a. STATE KANSAS b. COUNTY Clay	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS City		Length of stay in lb 1-MONTH	c. CITY OR TOWN Clay Center Inside Limits <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Lukes Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) R. F. D. # 3 Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Edward A. Gerriets		4. DATE OF DEATH Month Day Year June 2-1963	
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 July 6-1909
9. AGE (last birthday) 53		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) FARMER		10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (City and state or country) Clay Center KANSAS
12. CITIZEN OF WHAT COUNTRY U. S. A.		13a. FATHER'S NAME Carl Gerriets	
13b. MOTHER'S MAREN NAME Louise Hedden		14. NAME OF HUSBAND OR WIFE Florence Gerriets	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) No		16. SOCIAL SECURITY NO. 36	17. INFORMANT Address Florence Gerriets - Clay Center K
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastric Ulcer, Benign, with Gastrointestinal Hemorrhage			INTERVAL BETWEEN ONSET AND DEATH 3 months
DUE TO (b) intestinal Hemorrhage			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Diabetes Mellitus			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 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 May 12, 63 to June 2, 63 and last saw him alive on June 2, 63 Death occurred at 4 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Harold W. Voth, M.D.		22b. ADDRESS 4320 Wornall Rd. Kansas City, Mo.	22c. DATE SIGNED June 4, 63
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE June 4-1963	23c. NAME OF CEMETERY OR CREMATORY Datesville Cemetery	23d. LOCATION (City, town, or county) Clay County-KANSAS
24. FUNERAL DIRECTOR Gates, 1901 Olatha Blvd, Kansas City, Mo	25. DATE RECD. BY LOCAL REG. 6-4-63	26. REGISTRARS SIGNATURE Reth Song	

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK OR TYPEWRITER RIBBON

AUG 1 1963

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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 Paul B. Williamson

Licensed Embalmer No. 5009

P. O. Address Overland Park, Mo

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.