

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

2561

File No

Primary Registration District No

Registered No

FULL NAME

Gentle Lee Cindere

[If death occurred in a hospital or institution, give its NAME instead of street and number]

PERSONAL AND STATISTICAL PARTICULARS

SEX <i>Female</i>	COLOR OR RACE <i>black</i>	SINGLE ☒ MARRIED <i>MARRIED</i> WIDOWED OR DIVORCED (Write the word)
----------------------	-------------------------------	--

DATE OF BIRTH Nov 12 1898
(Month) (Day) (Year)

AGE 17 yrs. 2 mos. 17 ds. IF LESS than
1 day, hrs.
or min.?

OCCUPATION
(a) Trade, profession, or particular kind of work *Housewife*
(b) General nature of industry, business, or establishment in which employed (or employer) *Housewife*

BIRTHPLACE
(City or town, State or foreign country) Lakewood, MD

NAME OF FATHER *Kenneth Stephens*

NTS. BIRTHPLACE
OF FATHER *Baltimore MD*
(City or town, State or foreign country)

MAIDEN NAME
OF MOTHER *Leah...*

12	BIRTHPLACE (City or town, State or foreign country)	unknown
----	--	---------

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Charles Alexander

(ADDRESS) Bill Lower, Mo.

183 Bull

Filed 1916 Dec 31 J. F. Williams
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

29, 1916
(Day) (Year)

I HEREBY CERTIFY, that I attended deceased from June 28, 1916, to June 29, 1916, that I last saw her alive on June 28, 1916, and that death occurred, on the date stated above, at 6.9 m.

The CAUSE OF DEATH* was as follows:

Rupture of Pellyman
to the south with new shape etc
Pellyman County

Contributory Gestapic Pregnancy
(SECONDARY)
(Duration) yrs. 2 mos. 2 ds

(Signed) J. A. Bellamy M. D.
May 29, 1916 (Address) Bellamy

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.
Where was disease contracted _____
if not at place of death? _____

Former or
(usual) residence.....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Burial at sea	June 28, 1964

UNDERTAKER	ADDRESS
------------	---------

Chair: Murphy. | Bellflower.

PLACE OF DEATH

MISSOURI STATE BOARD OF HEALTH BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH

Revised United States Standard Certificate of Death

County _____

Township _____ or _____

Village _____ or _____

City _____

Registration District No. _____ File No. _____

Primary Registration District No. _____ Registered No. _____

(NO. _____ St. _____ Ward _____)

(If death on hospital or give its NAME of street and _____)

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH	(Month) _____ (Day) _____ (Year) _____	
AGE	_____ yrs. _____ mos. _____ ds.	If LESS than 1 day, _____ hrs. or _____ min.?

OCCUPATION

(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE
(City or town, State or foreign country) _____

NAME OF FATHER _____

BIRTHPLACE OF FATHER
(City or town, State or foreign country) _____

MAIDEN NAME OF MOTHER _____

BIRTHPLACE OF MOTHER
(City or town, State or foreign country) _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____, 191____,

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

(Month) _____ (Day) _____

I HEREBY CERTIFY, that I attended deceased

_____, 191____, to

that I last saw him alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

(Duration) _____ yrs. _____ mos.

Contributory

(SECONDARY)

(Duration) _____ yrs. _____ mos.

(Signed) _____

(Address) _____

*State the Disease Causing Death or, in deaths from Violent Causes, (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS INSTITUTIONS, TRANSIENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos.

Where was disease contracted if not at place of death?

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS