

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

Do not use this space.

16273

PLACE OF DEATH

County Buchanan

Registration District No. 85

Township.....

Primary Registration District No. 1001

City St. Joseph (No.)

St.

File No.

Registered No. 672

Ward.....

2. FULL NAME Samuel Ryburn Gaines

(a) Residence, No. 3006 Sylvan St., St. Joseph Ward, (If nonresident give city or town and State)

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Lorraine B.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 24 1870

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. 58 | 2 | 27

8. OCCUPATION OF DECEASED

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

(b) General nature of industry, business, or establishment in which employed (or employer) St. Joseph Paper Box Co

(c) Name of employer St. Joseph Paper Box Co

9. BIRTHPLACE (CITY OR TOWN) Unknown

(STATE OR COUNTRY) Andrew Co Mo

10. NAME OF FATHER Julius G. Gaines

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Unknown

(STATE OR COUNTRY) Kentucky

12. MAIDEN NAME OF MOTHER M. Ryburn

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Unknown

(STATE OR COUNTRY) Mason Co Mo

14. INFORMANT Lorraine B. Gaines

(Address) 3006 Sylvan St. St. Joseph

15. FILED 22 1928 John G. [Signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

3 16. DATE OF DEATH (MONTH, DAY AND YEAR) May 21 1928

17. I HEREBY CERTIFY, That I attended deceased from 5-20, 1928, to 5-21-28, 1928, that I last saw him alive on 5-20-28, 1928, and that death occurred, on the date stated above, at 7:00 A.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral embolism
87E
15B
36 (duration) yrs. mos. 4 ds.

CONTRIBUTORY (SECONDARY) Erysipelas (duration) yrs. mos. 8 ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH..... no DATE OF.....

WAS THERE AN AUTOPSY..... no

WHAT TEST CONFIRMED DIAGNOSIS..... Clinical

(Signed) Paul J. [Signature], M. D.

May 21, 1928 (Address) St. Joseph, Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

Chairman Park May 23 1928

20. UNDERTAKER ADDRESS

Heaton - [Signature] 319 S 10

[Signature]

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH
 County Buchanan Registration District No. 85 File No. _____
 Township _____ Primary Registration District No. 1001 Registered No. 672
 City St. Joseph (No. _____) St. _____ Ward _____

2. FULL NAME Samuel Ryburn Gaines
 (a) Residence. No. _____ St. _____ Ward _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) _____

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
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8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work _____
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

10. NAME OF FATHER _____

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

12. MAIDEN NAME OF MOTHER _____

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 21 19 28

17. I HEREBY CERTIFY, That I attended deceased from _____ 19____ to _____ 19____ that I last saw h. _____ alive on _____ 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral embolism
 (duration) _____ yrs. _____ mo. _____ ds.

CONTRIBUTORY (SECONDARY) Erysipelas - probably due to streptococcus terrificus
 (duration) _____ yrs. _____ mo. _____ ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH: _____
 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
 WAS THERE AN AUTOPSY? _____
 WHAT TEST CONFIRMED DIAGNOSIS? _____
 (Signed) Paul Longrave, M. D.
 _____, 19____ (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL _____ DATE OF BURIAL _____ 19____

20. UNDERTAKER _____ ADDRESS _____

14. INFORMANT _____ (Address) _____

15. FILED 8/6 98 John G. Galt REGISTRAR

SUPPLEMENTARY

REGISTERED - A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

