JUL 10 1928

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

Do not use this space.

19612

1. PLACE OF DEATH
County: S Stoddard — Registration District No.: 838 — File No.:
Township: — Primary Registration District No.: 4509 — Registered No.: 27
City: Dexter (No. ..., ... St. ... Ward)

2. FULL NAME: Evelyn Gales.

(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: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): infant

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Jan. 3 - 1927

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
1	4	11	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer): Infant
(c) Name of employer:

9. BIRTHPLACE (CITY OR TOWN): Piggot
(STATE OR COUNTRY): Ark.

PARENTS
10. NAME OF FATHER: Loyd Gales
11. BIRTHPLACE OF FATHER (CITY OR TOWN): (?)
(STATE OR COUNTRY): Tenn.
12. MAIDEN NAME OF MOTHER: Agnes Hunt
13. BIRTHPLACE OF MOTHER (CITY OR TOWN): Campbell
(STATE OR COUNTRY): Mo.

14. INFORMANT: Loyd Gales.
(Address): Dexter Mo.

15. FILED: 5-15, 1928 F. LaRue
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): May - 15 - 1928

17.
I HEREBY CERTIFY, That I attended deceased from May - 14 -, 1928, to May 15 -, 1928 that I last saw ... alive on May 14, 1928, and that death occurred, on the date stated above, at 12/15 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
fractured skull.
(Run over by an automobile)
21 D.M.
(duration) ... yrs. ... mos. 1 ds.

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

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
0 DID AN OPERATION PRECEDE DEATH? No DATE OF —
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) Frank LaRue, M. D
, 19 (Address) Dexter 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: Piggott Ark.
DATE OF BURIAL: 5-16-1928

20. UNDERTAKER: C. O. Biggs.
ADDRESS: Dexter Mo.

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.

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 Stoddard — Registration District No. 838 — File No.
Township — Primary Registration District No. 4509 — Registered No. 27
City Dexter (No. ..... St. ..... Ward)

2. FULL NAME Evelyn Gales
(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 F
4. COLOR OR RACE W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) S

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.

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)

PARENTS
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)

14. INFORMANT (Address)

15. FILED 7/19, 1928 F. Lahm REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 15, 1928

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:
Fractured skull
(Run over by an Automobile) in Dexter Mo.
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) 1880
(duration) ..... yrs. ..... mos. ..... 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) ....., 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

SUPPLEMENTARY

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. ...ACIANS sho... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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