

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

Do not use this space.

9072

1929

PLACE OF DEATH

County Saline
Township Arrow Rock
City _____ (No. _____) St. _____ Ward _____

Registration District No. 792
Primary Registration District No. 6035-A

File No. _____
Registered No. _____

2. FULL NAME Mrs. Ida R. Gambrell
(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) Divorced
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov. 27 - 1837
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
91 | 3 | . | |
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work at home
(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) Saline Co. Mo.
10. NAME OF FATHER Bernis Brown
11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) VA
12. MAIDEN NAME OF MOTHER Fancy Burton
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) VA

14. INFORMANT Mrs. Stafford (Address) State of Mo.
15. FILED 3-11-29 Frazer Morris REGISTRAR

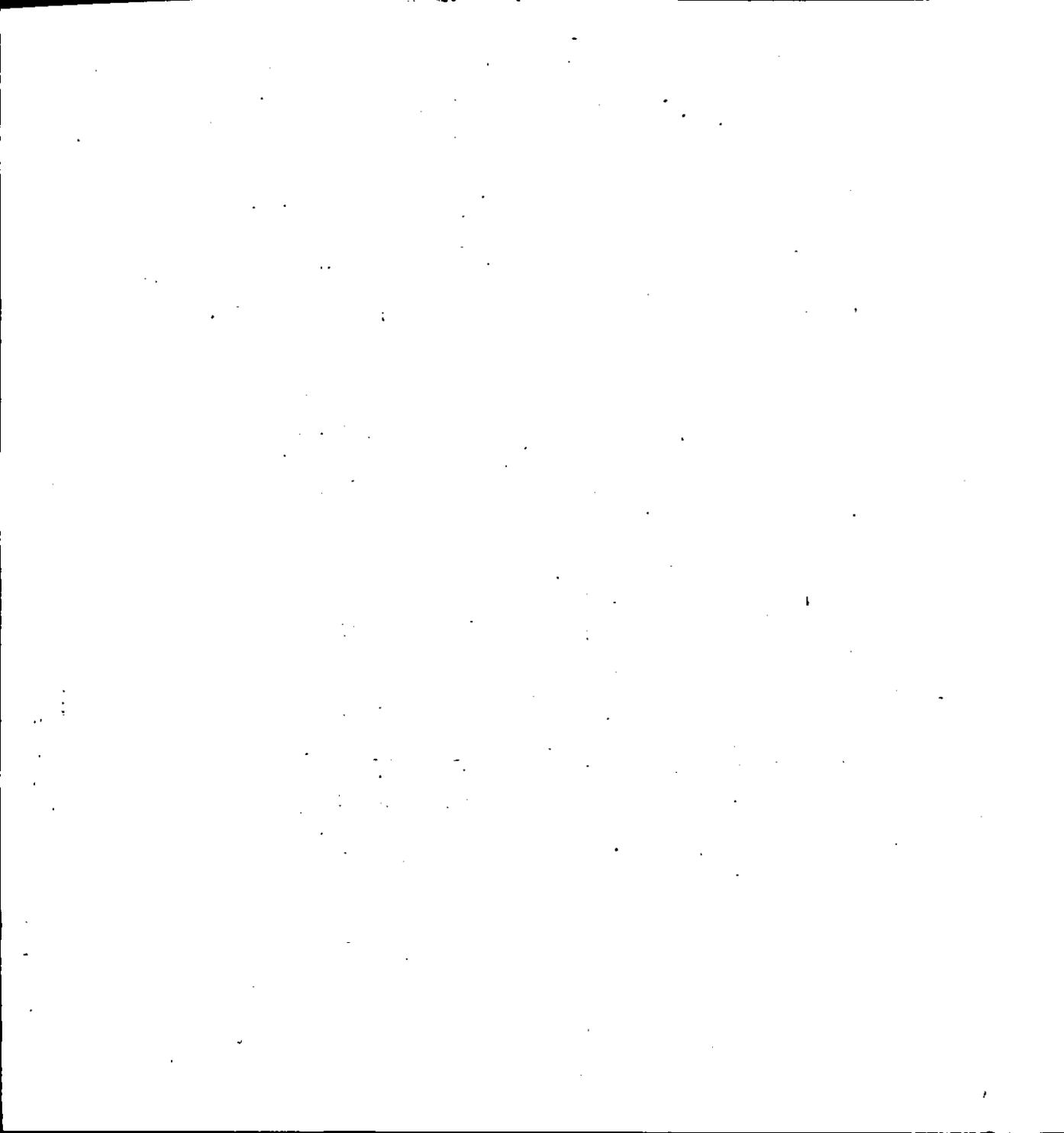
MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-27 1929
17. I HEREBY CERTIFY, That I attended deceased from 2-27, 1929, to 2-27, 1929, that I last saw him alive on 2-21, 1929, and that death occurred, on the date stated above, at 1-2 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
fracture of neck of femur
accidental fall
(duration) _____ yrs. _____ mos. 24 ds.
CONTRIBUTORY venile debility (SECONDARY) (duration) 2 yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH.
DID AN OPERATION PRECEDE DEATH? no DATE no
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? clinical
(Signed) M.D. Gillman, M. D. 2-28, 1929 (Address) Gillman

*State the DISEASE CAUSING DEATH, or in death from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
19. PLACE OF BURIAL, CREMATION, OR REMOVAL State City Cemetery DATE OF BURIAL 2-28 1929
20. UNDERTAKER? Hill Brothers ADDRESS State



REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW
 PHYSICIANS SHOULD BE STATED EXACTLY. Exact statement of OCCUPATION is very important
 cause of DEATH in plain terms, so that it may be properly classified.

1. PLACE OF DEATH
 County Saline Registration District No. 792 File No. 9072
 Township Arrow Rock Primary Registration District No. 6075-a Registered No.
 City..... (No.) St. Ward)

2. FULL NAME Mrs Ida R. Gambell
 (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

MEDICAL CERTIFICATE OF DEATH

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

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. ormin.
--------	-------	--------	------	--

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)

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2/27 1929
 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:
Fracture of neck of femur, 1855, accidental fall.
 (duration) yrs. mos. ds.
 CONTRIBUTORY (SECONDARY) (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.

SUPPLEMENTAL

14. INFORMANT (Address)
 15. FILED 3-11-29 Frank Morris REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
20. UNDERTAKER	ADDRESS

1

1964

MISSOURI STATE BOARD OF HEALTH

1964

NAME

ADDRESS

CITY

STATE

ZIP

DATE

TIME

REASON

INITIALS

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

26

27

28

29

30

31

32

33

34

35

36

37

38

39

40

41

42

43

44

45

46

47

48

49

50

51

52

53

54

55

56

57

58

59

60

61

62

63

64

65

66

67

68

69

70

71

72

73

74

75

76

77

78

79

80

81

82

83

84

85

86

87

88

89

90

91

92

93

94

95

96

97

98

99

100

101

102

103

104

105

106

107

108

MISSOURI STATE BOARD OF HEALTH

ALL INFORMATION CALLED FOR HEREIN IS UNCLASSIFIED

S-9072