JUL 24 1929

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

Do not use this space.

21004

1. PLACE OF DEATH
County Clay
Township Platte
City ..... (No. ..... St. ..... Ward)

Registration District No. 203
Primary Registration District No. 5281

File No. .....
Registered No. .....

2. FULL NAME Will 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 15 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male
4. COLOR OR RACE Black
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word) married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 7-2-1878

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
50	11	23	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farm Laborer
(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) Clay Co. Mo.

PARENTS

10. NAME OF FATHER Willis Gaines
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Mo
12. MAIDEN NAME OF MOTHER Fannie Wallace
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) unknown

14. INFORMANT Mrs. Will Gaines
(Address) Trimble, Mo. R.F.D.

15. FILED 7/10, 1929 E. C. Hill REGISTRAR

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MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6-25-1929

17. I HEREBY CERTIFY, That I attended deceased from Sept. 8, 1928, to Jan 25, 1929 that I last saw him alive on June 24, 1929, and that death occurred, on the date stated above, at 3:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Nephritis
131
(duration) 2 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Infection
(duration) 10 yrs. mos. ds.

12 PB

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) [signature], M. D.
July 3, 1929 (Address) Smithville 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 Mt Olivet Cem. Clay Co. Mo.
DATE OF BURIAL 6-26-1929

20. UNDERTAKER McCormas Undt. Co.
ADDRESS Smithville Mo

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

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