

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.

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

Do not use this space.

43291

1. PLACE OF DEATH
 County DePue Registration District No. 897
 Township Hazlewood Primary Registration District No. 6107
 City M. C. W. Gaslen (No. _____ St. _____ Ward _____)

2. FULL NAME M. C. W. Gaslen
 (a) Residence No. _____ St. _____ Ward _____
 (Usual place of abode)
 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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 10-1887

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
47 5 19

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work farmer
 (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) Mo.

PARENTS

10. NAME OF FATHER John Gaslen

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

12. MAIDEN NAME OF MOTHER Mary Fox

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

14. INFORMANT Joseph L. Gaslen
 (Address) Carthage, Mo.

15. FILED 12/30 1929 L. L. Watson
 REGISTRAR.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec. 29 1929

17. I HEREBY CERTIFY, That I attended deceased from 11-11 1929 to 12-29 1929 that I last saw him alive on 12-28 1929, and that death occurred, on the date stated above, at 7:45 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
suicide
gun shot wound of head
self inflicted
167 (duration) yrs. mos. ds.
 CONTRIBUTORY insane (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) E. H. Beers M. D.
12-30, 1929 (Address) Seymour Mo.

*State the DISEASE CAUSING DEATH, if 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 Masonic Cemetery DATE OF BURIAL 12/30 1929

20. UNDERTAKER L. L. Watson ADDRESS Seymour Mo.

