

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

Do not use this space.

1050 35

1. PLACE OF DEATH

County *St. Louis*
Township *113*
City *Kennett Mo* (No. *K.C. Kennett Mo*)

Registration District No. *399*
Primary Registration District No. *3002*

File No. _____
Registered No. _____
St. _____ Ward _____

2. FULL NAME

John Gail
(a) Residence No. *1225 Forest* St. *2* 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 *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Single*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *none*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Feb 12 1892*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
37 10 20

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *laborer*
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer *Chas Motor Co.*

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) *Ill.*
10. NAME OF FATHER *Fred. Gail*

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

12. MAIDEN NAME OF MOTHER *Mary Barber*

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

14. INFORMANT *Chas. Gail*
(Address) *Missouri Obola*

15. FILED *1/4 1930* *M.M. Crowe* REGISTRAR
asst

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Jan 2 1930*

17. *deputy coroner*
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:

Suicide. Gun am
167

CONTRIBUTORY (SECONDARY)

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 *histology, bacteriology*

(Signed) *Henry M. Allen* M. D.

1/2 1930 (Address) *deputy coroner*
*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 *Afton Obola* DATE OF BURIAL *1-4 1930*

20. UNDERTAKER *J. P. Lewis* ADDRESS *K. C. 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.

