

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.

APR 28 1930

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

Do not use this space.

8224

1. PLACE OF DEATH
 County Dent Registration District No. 266
 Township _____ Primary Registration District No. 4164
 City Salem (No. _____) St. _____ Ward _____

2. FULL NAME Ruby Illene Gearhart
 (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) single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar 20 - 1929

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
1 ----- 4

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) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Jadwin
 (STATE OR COUNTRY) Mo.

10. NAME OF FATHER Matt. Gearheart

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Dent
 (STATE OR COUNTRY) Co.

12. MAIDEN NAME OF MOTHER Martha Miller

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Phillipsburg
 (STATE OR COUNTRY) Kan

14. INFORMANT Matt Gearheart
 (Address) Jadwin Mo.

15. FILED 3/24/30 A. E. Ridd, M.D.
 (REGISTRAR)

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3/24/30
 17. I HEREBY CERTIFY, That I attended deceased from Mar 24 1930 to Mar 24 1930, and that I last saw him alive on Mar 24 1930, and that death occurred, on the date stated above, at _____

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Status Thymus Spleenitis.
Fibroid Cholecystitis.
 (duration) _____ yrs. _____ mos. _____ ds.
 CONTRIBUTORY (SECONDARY) Cause of fever unknown.
 (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED _____
 IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? No DATE OF _____
 WAS THERE AN AUTOPSY? No BY _____

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) Clayton H. Street, M. D.
 , 19 _____ (Address) Salem, 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 Jadwin Cemetery
 DATE OF BURIAL 3/23/30

20. UNDERTAKER Carl Spencer
 ADDRESS Salem Mo

