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.

18261

1. PLACE OF DEATH
County Saline — Registration District No. 796 — File No.
Township — Primary Registration District No. 3038 — Registered No. 57
City Marshall, Mo. (No. ..... St. ..... Ward)

2. FULL NAME Julia Estella Gorker
(a) Residence No. ..... St., ... Ward. ..... (If nonresident, give city or town and State)
(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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Female	White	Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 6, 1879

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
50	8	1	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Marshall, Mo.
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER Abraham Cain
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Illinois
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Lizzie J. Lile
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Hendon, Mo.
(STATE OR COUNTRY)

14. INFORMANT Mrs Cain (Mother)
(Address)

15. FILED 5-12, 1930 Mrs. John H. McGuire
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 7 1930

17. I HEREBY CERTIFY, That I attended deceased from April 21st, 1930, to May 7th, 1930 that I last saw her alive on May 7, 1930 and that death occurred, on the date stated above, at 8.25 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Tuberculosis of bowels
25
..... (duration) ..... yrs. 2 mos. ..... ds.

CONTRIBUTORY (SECONDARY) Thru about a year ago
..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH .....
DID AN OPERATION PRECEDE DEATH? No DATE OF X
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) A. C. Putnam, M. D.
5/8/1930 (Address) Marshall 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	DATE OF BURIAL
Slater, Mo	5-9 1930
20. UNDERTAKER	ADDRESS
J. L. Surrey	Marshall, Mo.