

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

Do not use this space.

25893

1. PLACE OF DEATH

County Buchanan

Registration District No. 81

File No. _____

Township _____

Primary Registration District No. 4049

Registered No. 9

City St. Joseph, Mo. (No. De Kalb, Missouri)

St. _____ Ward _____

2. FULL NAME

(a) Residence. No. _____ St. _____ Ward. De Kalb Missouri

(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) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) September 15 1873

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
56 | 10 | 26 | _____

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

9. BIRTHPLACE (CITY OR TOWN) Andrew County Missouri
(STATE OR COUNTRY)

10. NAME OF FATHER Jesse L. Gage

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Nodaway Co., Missouri
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Elizabeth Shipley

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Unknown Illinois
(STATE OR COUNTRY)

14. INFORMANT Mrs. Fannie Gage
(Address) De Kalb Missouri

15. FILED 8/12/30 J. W. McAdew
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) August 11, 1930

17. I HEREBY CERTIFY, That I attended deceased from 8/13/30 1930 to 8/11/30 1930
that I last saw her alive on 8/11/30 1930 and that death occurred, on the date stated above, at 10:20 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Carcinoma of Stomach
46 B
(duration) 1 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 44 B
(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

WHAT TEST CONFIRMED DIAGNOSIS hist. of test
(Signed) E. B. McAdew, M. D.

Aug 12, 1930 (Address) De Kalb 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 De Kalb Cemetery DATE OF BURIAL Aug. 13, 1930

20. UNDERTAKER Fleeman Funeral Home ADDRESS 1946 Calhoun

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.

UNFADE PUNILY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SEP 22 1930

