

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

Do not use this space.

14099

399

1. PLACE OF DEATH

County Jackson
Township Law
City K.C. Mo. (No. 6031 So. Benton)

Registration District No. _____
Primary Registration District No. 1002

File No. _____
Registered No. 15017
St. _____ Ward _____

2. FULL NAME

Minnie H. Gaines
(a) Residence. No. 6031 So. Benton St., 16 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Robert O. Gaines

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec-8-1863

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, ____ hrs. or ____ min.
	<u>67</u>	<u>3</u>	<u>27</u>	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(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) Indiana

10. NAME OF FATHER Frazer

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

12. MAIDEN NAME OF MOTHER No Record

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) no record

14. INFORMANT Robert A. Gaines (Address) 6031 So Benton

15. FILED 4/6 31 M. M. Lowe REGISTRAR Assn

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr-5-1931

17. I HEREBY CERTIFY, That I attended deceased from July 2-3, 1923, to 4-5, 1931 that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at 8:15 pm m.

THE CAUSE OF DEATH* WAS AS FOLLOWS
Angina Pectoris
9/12/23
14008
CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ da.

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? Physiologist's
(Signed) W. S. Koelich M. D.
4-6-1931 (Address) 737 Lantry Bldg

*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 Slater Mo DATE OF BURIAL 4-6-1931

20. UNDERTAKER Mrs. C. L. Foster 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.

WITH UNFADING INK—THIS IS A PERMANENT RECORD

Dr. Holister Gallup - Vi-9628
2614-E-9th
9-9:30 AM

Res - Ri-3199

736 Ketchikan Bluff

12: Noon