

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

Do not use this space.

27974

1. PLACE OF DEATH

County Franklin Registration District No. 297
 Township Washington Primary Registration District No. 316
 City Washington (No. _____, _____ St. _____ Ward)

File No. _____

Registered No. 934

2. FULL NAME Anton H. Gail

(a) Residence, No. Main & Jefferson Sts. St. _____ Ward. _____
 (Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 61 yrs. 2 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Widowed</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF <u>AMANDA GAIL SCHAEFNER</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>June 18, 1872</u>		
7. AGE YEARS <u>61</u>	MONTHS <u>2</u>	DAYS <u>9</u>
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.		11. Total time (years) spent in this occupation <u>Retired Painter</u>
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.		
10. Date deceased last worked at this occupation (month and year)		

12. BIRTHPLACE (CITY OR TOWN) Washington
 (STATE OR COUNTRY) Missouri

13. NAME Henry Gail

14. BIRTHPLACE (CITY OR TOWN) Germany
 (STATE OR COUNTRY)

15. MAIDEN NAME Gertrude Proff

16. BIRTHPLACE (CITY OR TOWN) Germany
 (STATE OR COUNTRY)

17. INFORMANT Walter Eick
 (ADDRESS) Main & Jefferson, Washington, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Odd Fellow Cemetery DATE Aug. 28, 1931

19. UNDERTAKER Otto & Co.,
 (ADDRESS) Washington, Mo.

20. FILE Aug 28 1931 P. L. Murch
 Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 27, 1931

I HEREBY CERTIFY, That I attended deceased from July 30, 1931, to Aug 27, 1931

I last saw him alive on Aug 27, 1931. Death is said

to have occurred on the date stated above, at 9:50 a.m.

The principal cause of death and related causes of importance were as follows:

Tuberculosis of
Prostate & Ovary
99

Other contributory causes of importance:

Heart Disease

Name of operation no Date of no

What test confirmed diagnosis? Clinical Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? no Date of injury _____, 19____

Where did injury occur? _____
 (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

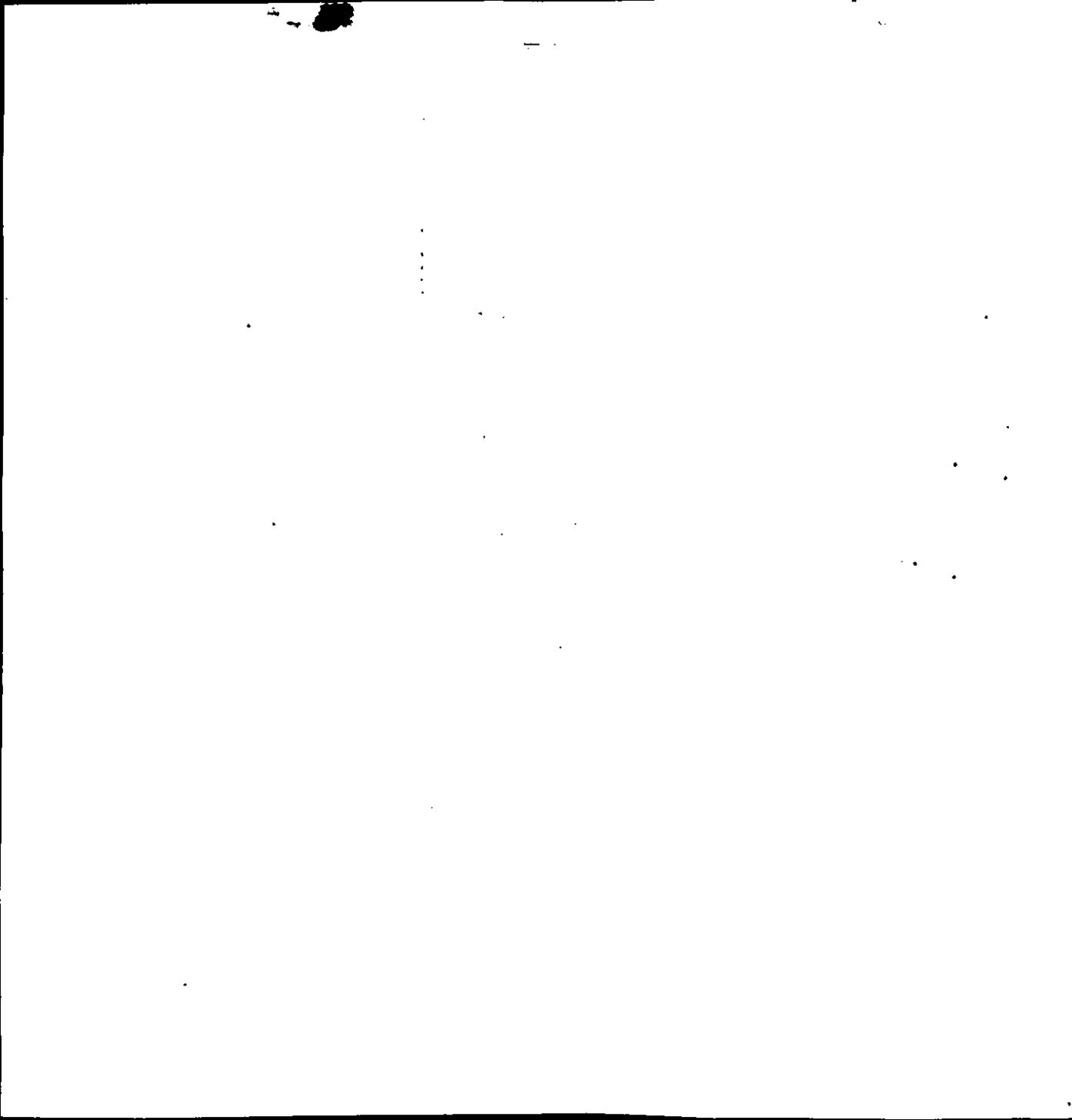
Manner of injury no

Nature of injury no

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify _____

(Signed) R. R. Costley, M. D.
 (Address) Washington, Mo.



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ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Franklin Registration District No. 297 File No.
 Township Primary Registration District No. 2016 Registered No. 94
 City Washington (No.) St. Ward)

2. FULL NAME Arton H. Gail

(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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Wid

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 18-1872

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
59 2 9

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work (duration) yrs. mos. ds.
 (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)

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT (Address)

15. FILED Aug 31 1919 O. L. Munch REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 27 1919

17. I HEREBY CERTIFY That I attended deceased from 19....., 19..... that I last saw h..... alive on 19....., and that death occurred, on the date stated above, at

THE CAUSE OF DEATH WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH:

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) M. D. , 19 (Address)

*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

20. UNDERTAKER ADDRESS

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFYING IF THEY ARE COMPLETELY PRESCRIBED BY LAW

SUPPLEMENTARY

HTbTE-S