

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

Do not use this space.

18459

File No. 109
Registered No. 109

1. PLACE OF DEATH *Texas*
107 County *Current* Registration District No. *866*
Township *Current* Primary Registration District No. *6146*
City (No.) St. (Ward)

2. FULL NAME *Lonzo Wane Gale*
(a) Residence, No. St. Ward.
(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 *male* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Infant*

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *1-30-32*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. *18*

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.
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)
11. Total time (years) spent in this occupation *8*

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Hartshorn mo*

FATHER
13. NAME *Calvin Gale*
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *mo*

MOTHER
15. MAIDEN NAME *Jna Day*
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Hartshorn mo*

17. INFORMANT *Calvin Gale*
(ADDRESS) *Hartshorn mo*

18. BURIAL, CREMATION, OR REMOVAL
PLACE *Dewitt Cem* DATE *6-1-32*

19. UNDERTAKER *Frank Stark*
(ADDRESS) *Hartshorn mo*

20. FILED *7-9* *32 mo* *W. H. ...*
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *5-30*, 19*32*

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____.

I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at *4-30 p.m.*

The principal cause of death and related causes of importance were as follows:
cause of death
unknown
VOO B
1-0-0-13
7

Other contributory causes of importance: _____

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ 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 _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____
(Signed) *Local Registrar* M. D.
(Address) *Hartshorn 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.

III 27 1932

State of New York
County of ...

... ..
... ..

... ..
... ..

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Texas Registration District No. 866
Township Current Primary Registration District No. 6146
City (No.) St. Ward

File No. _____
Registered No. 109

2. FULL NAME

Lonzo Warrin Gale
(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. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) S
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 5-12-1932
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
18

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. _____
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) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

13. NAME _____

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

15. MAIDEN NAME _____

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

17. INFORMANT (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE 19__

19. UNDERTAKER (ADDRESS) _____

20. FILED 7-9 1932 ans wrr omc
Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 30, 1932

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____

I last saw him alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

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

Date of onset _____

Other contributory causes of importance: _____

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ 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 _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

(Signed) _____, M. D.

(Address) _____

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

ry item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN's statement of OCCUPATION is v. nt. DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is v. nt.

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