

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

Do not use this space.

FEB 27 1934

11947

1. PLACE OF DEATH
County Monticau Registration District No. 598
Township 4th Primary Registration District No. 1
St. _____ Ward _____
2. FULL NAME Ollie Gabriel
(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. (If nonresident, give city or town and State)

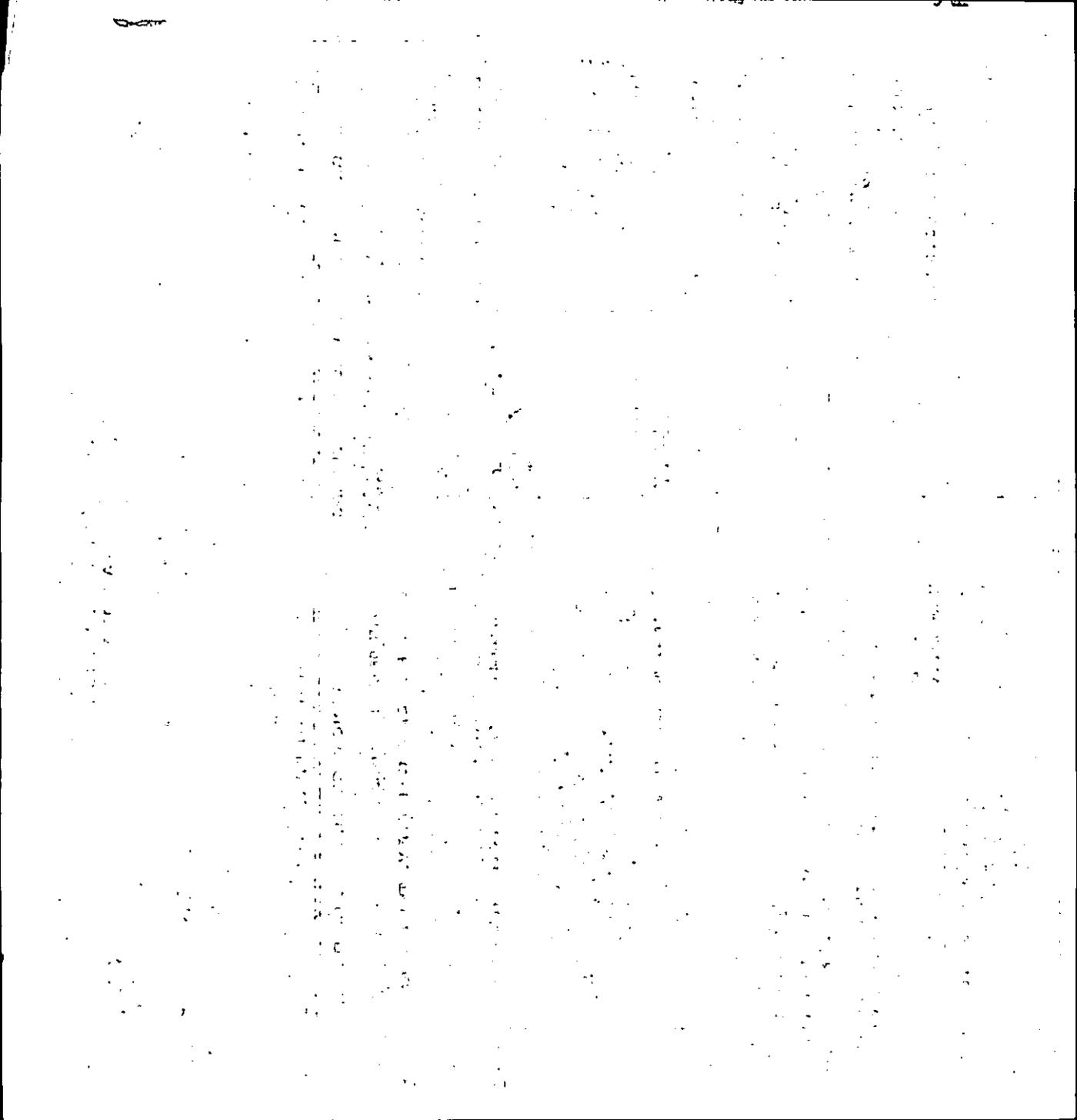
PERSONAL AND STATISTICAL PARTICULARS

3. SEX F.M. 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widow
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 30-1854
7. AGE YEARS 79 MONTHS 2 DAYS 16 If LESS than 1 day, _____ hrs. or _____ min.
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) Indiana
13. NAME Isriel Luckenbill
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Penn.
15. MAIDEN NAME Phoebie Dayton
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ohio
17. INFORMANT (ADDRESS) Mrs. Louis Comer, Versailles, Mo.
18. BURIAL, CREMATION, OR REMOVAL PLACE Hopewell DATE Jan 13, 1934
19. UNDERTAKER (ADDRESS) W. F. Kidwell, Versailles, Mo.
20. FILED 1-17 1934 H. N. Lutman Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 11, 1934
22. I HEREBY CERTIFY That I attended deceased from Dec 1st, 1933, to Jan 11, 1934. I last saw her alive on Jan 11, 1934. Death is said to have occurred on the date stated above, at 10:5 A. m.. The principal cause of death and related causes of importance were as follows:
Bright Disease complicated with Pneumonia of right lung.
Other contributory causes of importance:
108 132A
Name of operation _____ Date of _____
What test confirmed diagnosis? Symptoms Was there an autopsy? Yes
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? Yes. If so, specify Bright Disease. (Signed) H. E. Blacksten, M. D. (Address) Versailles Mo. IRI

22 22 72



**MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Morgan
Township Versailles
City Versailles (No.)

Registration District No. 598
Primary Registration District No. 4353

File No. 1947
Registered No. 1
St. Ward)

2. FULL NAME

Ollie Gabriel

(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

MEDICAL CERTIFICATE OF DEATH

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

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 11, 1934

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

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

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.

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

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.....

Other contributory causes of importance:

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

Bright disease complicated with pneumonia of lobes pneumonia
Date of onset

13. NAME

Name of operation..... Date of.....

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

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

15. MAIDEN NAME

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide?..... Date of injury....., 19.....

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

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

17. INFORMANT (ADDRESS)

Manner of injury.....
Nature of injury.....

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

24. Was disease or injury in any way related to occupation of deceased?.....
If so, specify.....

19. UNDERTAKER (ADDRESS)

(Signed)....., M. D.

20. FILED 19 1 H. N. Lutman Registrar.

SUPPLEMENTARY

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

5-1947