

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

Do not use this space.

MAY 25 1934

1. PLACE OF DEATH

County atw
Township ~~Springfield~~
City Salem (No.)

Registration District No. 266
Primary Registration District No. 416A

File No. 12406
Registered No. 28

2. FULL NAME

Joseph Franklin Gains

(a) Residence, No. _____ St. _____ Ward. _____
(Usual place of abode)

Length of residence in city or town where death occurred 10 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 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 Lula Gains

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 4 1874

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min. 60 8

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Laborer

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) West Co. Mo.

13. NAME Taylor Gains

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

15. MAIDEN NAME Verlina Nelson

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) West Co. Mo.

17. INFORMANT (ADDRESS) Erbert Gains
Dart Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE New Hope Mo. DATE 4/13 1934

19. UNDERTAKER (ADDRESS) A. W. Holston
Salem Mo.

20. FILED 4/13 1934 F. C. Ruedt. No. 10
Registrar.

2 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4-12 1934

22. I HEREBY CERTIFY, That I attended deceased from April 12 1934 to April 19 1934
I first saw him alive on April 12 1934 Death is said to have occurred on the date stated above, at 8 A. m.
The principal cause of death and related causes of importance were as follows:

apoplexy
stroke
Other contributory causes of importance: High Tension
Date of onset 4-12-34
8-16-33

Name of operation None Date of _____
What test confirmed diagnosis? 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)

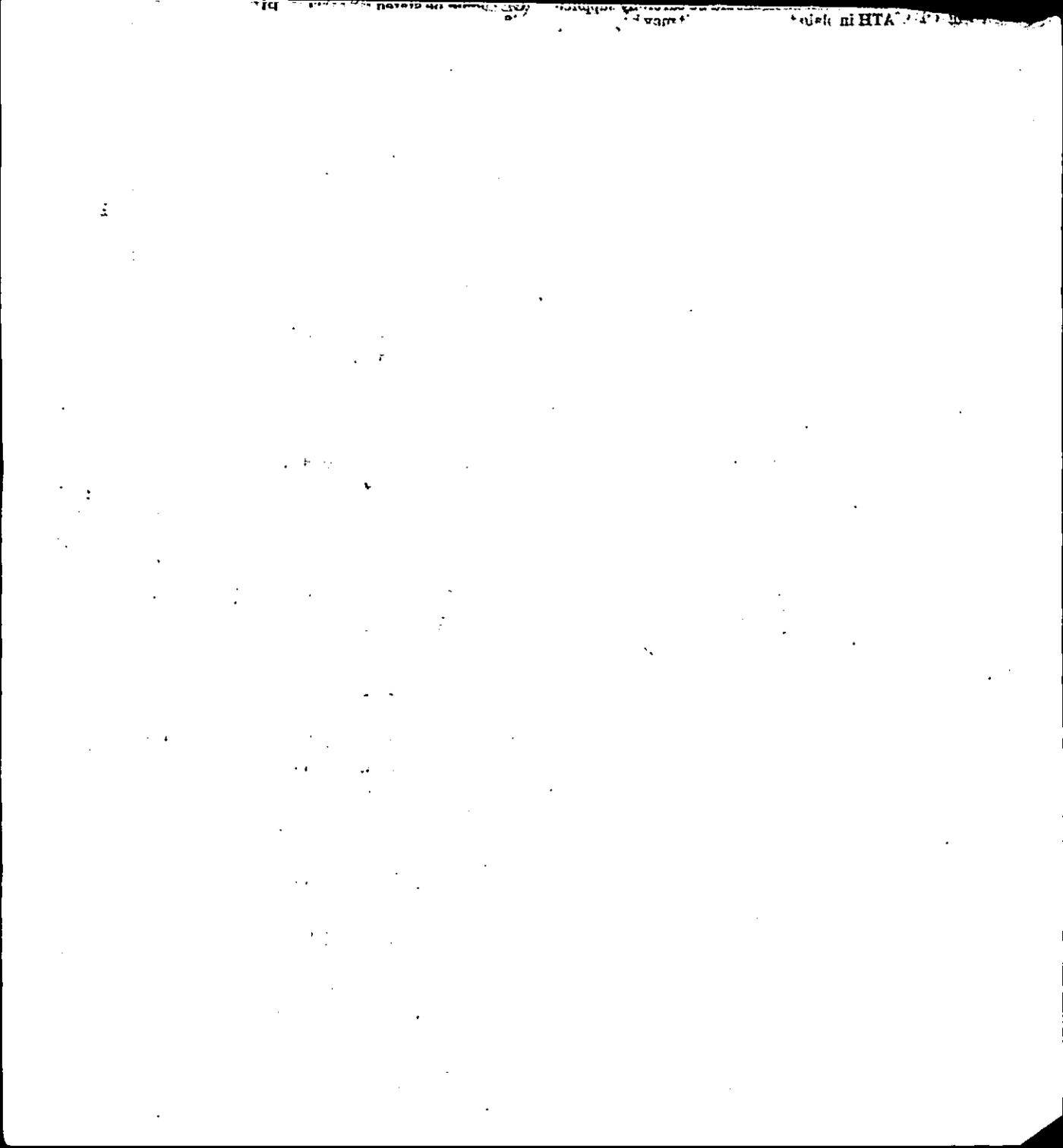
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? No.
If so, specify _____

(Signed) F. G. Dineen M. D.
(Address) Salem Mo.

RECORD OF DEATH IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED. EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT.



**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 West
Township Salem
City Salem (No. _____ St. _____ Ward)

Registration District No. 266
Primary Registration District No. 4164

File No. _____
Registered No. 28

2. FULL NAME

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

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

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

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

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 _____

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

FATHER 13. NAME _____

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

MOTHER 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 _____ 19 1

Registrar _____

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Apr 12 1934

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

I last saw h. _____ 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:

apoplexy

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 COMPLETED AS PRESCRIBED BY LAW.

CAUTION: ATN, in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS should state CAREFULLY the nature of the injury. AGE should be stated EXACTLY. PHYSICIANS should state CAREFULLY the nature of the injury.

5-12406