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.

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

JUN 19 1935

Do not use this space.

15901

File No.
Registered No.

1. PLACE OF DEATH

24 County: Clay — Registration District No.: 198
Township: ~~Fishing River~~ — Primary Registration District No.: 3611
City (No.): Excelsior Springs, Missouri. Vets. Adm. Facility St.: 3d Ward:

2. FULL NAME GASTON, James H.

(a) Residence, No.: Vets. Adm. Facility St.: Ward: Harrisonville, Mo.
(Usual place of abode) Excelsior Springs, Mo (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 0 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR): Dec. 22, 1863

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	71	5	4	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.: Musician
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.: unknown
10. Date deceased last worked at this occupation (month and year): unknown
11. Total time (years) spent in this occupation: unknown

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

FATHER

13. NAME: James Gaston (deceased)
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Kentucky

MOTHER

15. MAIDEN NAME: Susan Helsm (deceased)
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Missouri

17. INFORMANT: Hospital Records
(ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL
PLACE: Harrisonville, Mo DATE: May 24, 1935, 19

19. UNDERTAKER: Herbert Hope
(ADDRESS): Excelsior Springs, Mo

20. FILED: 5-24-, 1935 Mrs Rea McCracken
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): May 23, 1935, 19

22. I HEREBY CERTIFY, That I attended deceased from Apr. 27, 1933, 19, to May 23, 1935, 19
I last saw him alive on May 23, 1935, 19. Death is said to have occurred on the date stated above, at 11:30 P.M.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Atrophic sclerosis of liver	

Other contributory causes of importance:
Hemorrhage into the stomach
Passive congestion, spleen
Polycystic kidneys

Name of operation: None Date of: -
What test confirmed diagnosis? Obs. & Exam 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) H. C. HARDEGREE, Clinical Director, M. D.
(Address) Vets. Adm. Facility
Excelsior Springs, Mo.