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

Do not use this space.

SEP 18 1935

35

25603

1. PLACE OF DEATH

County Buchanan — Registration District No. 1001 — File No. 819

Township — Primary Registration District No. — Registered No.

City St Joseph (No. State Hospt. #2 St. Ward)

2. FULL NAME Selby Gaines

(a) Residence, No. Hoff County St., Ward. (If nonresident, give city or town and State)
(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 Female — 4. COLOR OR RACE White — 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widow

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 3-1884

7. AGE 51 YEARS — MONTHS 2. — DAYS 28. — If LESS than 1 day, ...hrs. or ...min.

OCCUPATION

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

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) Iowa

FATHER

13. NAME John Norris

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

MOTHER

15. MAIDEN NAME Alsinda Kaiser

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

17. INFORMANT (ADDRESS) Mrs Gene Wilson 1617 Faraon

18. BURIAL, CREMATION, OR REMOVAL PLACE Liberty, Nebr. DATE Aug. 4, 1935

19. UNDERTAKER (ADDRESS) FLEEMAN MORTUARY, INC. St Joseph Mo

20. FILED 8-2, 1935 John R Bender Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 1- 1935

22. I HEREBY CERTIFY: That I attended deceased from April 25, 1935 to Aug 1-, 1935

I last saw him alive on Aug 1-, 1935. Death is said to have occurred on the date stated above, at 2:45 P.M.

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

Aortic Regurgitation — Date of onset

Mitral insufficiency

Other contributory causes of importance:

Name of operation — Date of — No

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? No

If so, specify

(Signed) Jas Keaney, M. D.

(Address) Hospital 2