

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.

1939 JAN 13 1939

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

41710
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399
 (b) Township Kaw Primary Registration District No. 1002
 (c) City Lansing City (d) Street No. 5418 Sada St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

Registered No. 4776

2. PRINT FULL NAME

(a) Residence, No. 5418 Sada St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE wh 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug 31 - 1896

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
62 3 6

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as saw mill, bank, etc. Housework
 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) Kans

FATHER 13. NAME Walter Shannon

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

MOTHER 15. MAIDEN NAME Marion Maynic

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

17. INFORMANT (ADDRESS) Douglas D. Gale
5418 Sada

18. BURIAL, CREMATION, OR REMOVAL Edwardsville DATE Dec 8 1938

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Peris Anderson
1111 W. 1st St

20. FILED Dec 8 1938 M. M. Crowe
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 6 1938

22. I HEREBY CERTIFY, That I attended deceased from Dec 2, 1938, to Dec 6, 1938

I last saw her alive on Dec 6 - 58, 1938. Death is said

to have occurred on the date stated above, at 3 p. m.

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

Hypertension Date of onset Apr 3 year
620

Other contributory causes of importance: Apoplexy 49ap

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy? no

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) R. L. St. Louis, M. D.

(Address) 5242 St. John

Dr. R. P. St. Clair
5242 St. Johns

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

....., or by

Registered Apprentice No., working under my personal supervision.

Signed.....

Licensed Embalmer No.

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.