

REC'D APR 15 1939

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

11818
Do not use this space.

1. PLACE OF DEATH

(a) County Pemiscot Registration District No. 1102
(b) Township Pascola Primary Registration District No. 7850 Registered No. _____
(c) City Bragg City (d) Street No. 2370 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.

2. PRINT FULL NAME

330 Martha Florence Gatewood
(a) Residence, No. _____ St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF John Gatewood
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan 1, 1875
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 64 1 5
OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housekeeper
9. Industry or business in which work was done, as 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) Ligon Co. Ky
FATHER 13. NAME George Champ Gates
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown
MOTHER 15. MAIDEN NAME Plinie Dooms
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown
17. INFORMANT (ADDRESS) Lylean Smith
Bragg City Mo.
18. BURIAL, CREMATION, OR REMOVAL PLACE Sandy Ridge DATE Feb. 7 1939
19. FUNERAL DIRECTOR (NAME) (ADDRESS) J. C. Fox
7th. cont. mo.
20. FILED Feb. 9 1939 Mrs T. L. Cole
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb. 6, 1939
22. I HEREBY CERTIFY, That I attended deceased from Jan. 29, 1939, to Feb. 6, 1939
I last saw him alive on Jan. 30, 1939. 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:
Chronic myocarditis
myocarditis insufficiency
A. C.
Date of onset _____
Other contributory causes of importance:
chronic cholecystitis
Name of operation: _____ Date of _____
What test confirmed diagnosis? 2 x R 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? no
If so, specify _____
(Signed) Adshrey, M. D.
(Address) Mayfield, Mo.

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.

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.