

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

1930
Do not use this space.

REC'D JUN 14 1939

1. PLACE OF DEATH
 (a) County New Madrid Registration District No. 55
 (b) Township Gunderson Primary Registration District No. 4033
 (c) City Gibson mo (d) Street No. _____ 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. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.
 2. PRINT FULL NAME 300 C. L. My Cade
 (a) Residence, No. _____ 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 White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF James Cade
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 1 1879
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 60 1 18
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife
 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) May 1 1939 11. Total time (years) spent in this occupation _____
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Gibson mo
 FATHER 13. NAME Henry Creston
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) mo
 MOTHER 15. MAIDEN NAME Peralee Imboden
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) mo
 17. INFORMANT (ADDRESS) James Cade Gibson mo
 18. BURIAL, CREMATION, OR REMOVAL PLACE Stoutfield DATE May 13 1939
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) Rayd Russell
 20. FILED June 10, 1939 M. V. Murrema Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 12 1939
 22. I HEREBY CERTIFY That I attended deceased from May 1 1939 to May 12 1939
 I last saw him alive on May 11 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:
Porte Regulator with falling Compensation Date of onset _____
 Other contributory causes of importance: none
 Name of operation none Date of _____
 What test confirmed diagnosis? Chemical Was there an autopsy? no
 23. If (death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? no Date of injury _____, 19____
 Where did injury occur? none (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.
 Manner of injury none
 Nature of injury none
 24. Was disease or injury in any way related to occupation of deceased? no
 If so, specify _____
 (Signed) B. B. Baird, M. D.
 (Address) Gibson mo

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.