

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

33751
Do not use this space.

1. PLACE OF DEATH

(a) County Vernon Registration District No. 875
 (b) Township _____ Primary Registration District No. 3039 Registered No. 252
 (c) City Nevada or _____ (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. moa. da.

2. PRINT FULL NAME

Bessie Rebecca Gose
 (a) Residence, No. 322 N. Cedar 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 (write the word) Widow
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Mar. 31 1868
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. min.
71 5 26
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Bookkeeper
 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 _____

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 26 1939
 22. I HEREBY CERTIFY, that I attended deceased from May 29 1939 to Sept 26 1939
 I last saw her alive on Sept 25 1939. Death is said to have occurred on the date stated above, at 6:30 A.M.
 The principal cause of death and related causes of importance were as follows:
Chronic Endocarditis Date of onset 1938

Other contributory causes of importance: _____

12. BIRTHPLACE (CITY OR TOWN) Vernon County (STATE OR COUNTRY) Missouri

FATHER 13. NAME Nicholas M. Hawkins

14. BIRTHPLACE (CITY OR TOWN) Kentucky (STATE OR COUNTRY) _____

MOTHER 15. MAIDEN NAME Harriet Clendenen

16. BIRTHPLACE (CITY OR TOWN) Virginia (STATE OR COUNTRY) _____

17. INFORMANT Mrs. Ida May Kennedy (ADDRESS) 379 N. Ave 57, Los Angeles, Calif.

18. BURIAL, CREMATION, OR REMOVAL PLACE Milo Cemetery DATE Sept 28 1939

19. FUNERAL DIRECTOR (NAME) Stage Funeral Service (ADDRESS) Nevada Mo.

20. FILED Sept 28 1939 Ellen E. Hays Local Registrar.

Name of operation _____ Date of _____
 What test confirmed diagnosis? Phys. 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? No
 If so, specify _____
 (Signed) J. H. FOVE, M. D.
 (Address) Nevada, 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.

RECEIVED
DISTRICT HEALTH OFFICER
NO. 7
DISTRICT FILE NO. 7-39-1436
DATE FILED 10-10-39

RECEIVED

District Health Officer No. 7,

District File Number 7-39-1436

Date Filed 10-10-39

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 Allen V. Hays

Licensed Embalmer No. 1968

P. O. Address Nevada, Mo

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.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

33751
Do not use this space.

1. PLACE OF DEATH

(a) County Vernon Registration District No. 878
(b) Township _____ Primary Registration District No. 3039 Registered No. _____
(c) City Nevada (d) Street No. _____
(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 Bessie Rebecca Goss

(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 7 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) wid

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
71 5 26

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.
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)

FATHER 13. NAME
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 9/27 1939 Allen Wayne Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 26, 1939

22. I HEREBY CERTIFY, That attended deceased from _____ to _____, 19____

I last saw h. _____ alive on _____, 19____. 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:

Date of onset

Other contributory causes of importance:

Name of operation _____ Date of _____

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? _____

If so, specify _____ (Signed) J. W. Goss, M. D.

(Address) Nevada

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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

SUPPLEMENTARY

