

K. 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.

DEC 15 1939

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

39375
Do not use this space.

1. PLACE OF DEATH

(a) County Clinton Registration District No. 207

(b) Township Plattsburg, Mo Primary Registration District No. 4125- Registered No. 27-26

(c) City Plattsburg, 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 Elizabeth Gatewood Trause

(a) Residence, No. Plattsburg, Mo 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) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED Widowed
HUSBAND OF William Trause
(OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Mar 7 - 1849

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day,hrs. ormin.
<u>90</u>	<u>8</u>	<u>5</u>		

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. Housekeeping

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) Clinton Co Mo

FATHER

13. NAME George Washington Thompson

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

MOTHER

15. MAIDEN NAME Elizabeth Gatewood

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

17. INFORMANT (ADDRESS) Mrs Albert Hawks
Plattsburg Mo

18. BURIAL, CREMATION, OR REMOVAL
PLACE Green Lawn Sect DATE Nov 13, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) B. J. Wines
Plattsburg Mo.

20. FILED Nov 13, 1939 Emmie Crain
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 11, 1939

22. I HEREBY CERTIFY, That I attended deceased from Nov 9, 1939, to Nov 11, 1939

I last saw her alive on Nov 11, 1939 Death is said to have occurred on the date stated above, at 11:20 P. M.

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

Chronic Endocarditis

92.0

Date of onset 1939

Other contributory causes of importance:
Emphysema & Cholecystitis

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 no
(Signed) P. M. Stecker M. D.
(Address) Plattsburg Mo.

RECEIVED
District Health Officer No. 11,
District # 1239-1711
Date Recd. DEC 14 1939

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.....

Jas L Martin, Registered Apprentice No. 860
working under my personal supervision.

Signed *Jas L Martin*
Licensed Embalmer No. 860
P. O. Address Plattsburgh

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

39375
Do not use this space.

1. PLACE OF DEATH
 (a) County Clinton Registration District No. 207
 (b) Township Primary Registration District No. 4125 Registered No.
 (c) City Plattsburg (d) Street No.
 (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.
 (If death occurred in Hospital or Institution, write its name instead of street and number) St.
 2. PRINT FULL NAME Elizabeth Gatewood TRANSUE?
 (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 F 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.
90 8 5
 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.....
 19. FUNERAL DIRECTOR (ADDRESS)
 20. FILED Feb 3 1940 Bessie Chastain Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 11 1939
 22. I HEREBY CERTIFY, That I attended deceased from to
 I last saw him 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) P. M. Steckman M. D.
 (Address) Plattsburg

SUPPLEMENTARY

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.

