

DEC 18 1939

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

40647
Do not use this space.

1. PLACE OF DEATH

(a) County Ripley Registration District No. 755
 (b) Township Gatewood Primary Registration District No. 6245 Registered No. 1637
 (c) City (d) Street No. St.
 (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

(a) Residence, No. 203 Samuel Gaer Pass 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 M. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan 1 - 1861

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hra. ormin.
78 10 15

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer

9. Industry or business in which work was done, as saw mill, bank, etc.

10. Data 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) Ripley Co Mo

13. NAME Cal Pass

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) not known

15. MAIDEN NAME not known

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

17. INFORMANT (NAME) (ADDRESS) Wm C Coarier
Gatewood, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Rocky Mo DATE 11-15-39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) none

20. FILED 11-15-39 R. D. Strator Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov - 15 1939

22. I HEREBY CERTIFY, That I attended deceased from Oct 1st 1939, to Nov - 15 1939
 I last saw h. alive on Oct 27 1939 Death is said to have occurred on the date stated above, at 29 m.
 The principal cause of death and related causes of importance were as follows:

Hypertensive
Arterio Sclerotic
Date of onset 131

Other contributory causes of importance: 131

Chronic nephritis
and uremia

Name of operation none Date of
 What test confirmed diagnosis? blood 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 Stethoscope M. D.
 (Signed) W. D. Strator
 (Address) Gatewood 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.

RECEIVED

District Health Officer No. **5**

Signed.....

District File Number **1239576**

Licensed Embalmer No.....

Date Filed **12.21.39**

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.