

Registration District No. **496**

Primary Registration District No. **3025**

Registrar's No. **47**

1. PLACE OF DEATH:

(a) County Linn
(b) City or town Brookfield
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

8. (a) PRINT FULL NAME Raymond Lawrence Gacey
8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Dorothy Sportsman Gacey 6. (c) Age of husband or wife if alive 25 years
7. Birth date of deceased April 23 1910
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>30</u>	<u>1</u>	<u>7</u>	hr. min.

9. Birthplace Hutchinson Kansas
(City, town, or county) (State or foreign country)

10. Usual occupation Jumbler-Pickler

11. Industry or business tinware manufacture

MOTHER FATHER
12. Name Edward Gacey
13. Birthplace Dont know Mo
(City, town, or county) (State or foreign country)
14. Maiden name Georganna Sportsman
15. Birthplace Dont know Mo
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Dorothy Lee Gacey
(b) Address Milwaukee Wisc

17. (a) removal (b) Date thereof June 3, 40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Elgin Illinois

18. (a) Signature of funeral director James McLaughlin

(b) Address Marquette Mo

19. (a) 5/31/40 (b) Walter Lucas
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Wisconsin County Milwaukee
(b) _____
(c) City or town Milwaukee
(If outside city or town limits, write "RURAL")
(d) Street No. 91st St & Wilbur
(If rural, give location)
(e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 30
year 1940 hour 11:00 minute 30 P.M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Head crushed
Automobile accident
Due to Passenger in automobile
Due to Car over rear end
Inquest
Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy _____

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) Accident
(b) Date of occurrence May 30, 40
(c) Where did injury occur? Brookfield Tenn. Mo
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Interstate Highway 36 and 711
(Specify type of place) (e) Means of injury _____

23. Signature Walter Lucas (M. D. or other) _____
Address Brookfield Mo Date signed 5/31/40

1 X 3511 USE CONTINUING BLACK INK—MAKE A PERMANENT RECORD

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.

210 78-

RECEIVED
District Health Officer No. 11,
District File Number 640-824
Date Filed JUN 4 1940

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 Dale Bunch

Licensed Embalmer No. 4088

P. O. Address Marceline M

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.

o. 2B
-21-40
X22639

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 18898

Registration District No. 496

Primary Registration District No. 3025-

Registrar's No. 47

1. PLACE OF DEATH:

(a) County Linn
(b) City or town Bronfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution..... (Specify whether
In this community.....
* years, months or days)

3. (a) PRINT FULL NAME Raymond Lawrence Lacey
3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m
6. (b) Name of husband or wife..... 6. (c) Age of husband, or wife, if alive..... year

7. Birth date of deceased..... (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
30 1 7 hr. min.

9. Birthplace..... (City, town, or county) (State or foreign country)

10. Usual occupation.....

11. Industry or business.....

12. Name.....

13. Birthplace..... (City, town, or county) (State or foreign country)

14. Maiden name.....

15. Birthplace..... (City, town, or county) (State or foreign country)

16. (a) Informant.....

(b) Address.....

17. (a)..... (b) Date thereof..... (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) Mrs. G. H. O. (b) Franklin (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....
(c) City or town..... (If outside city or town limits write "RURAL")
(d) Street No..... (If rural, give location)
(e) If foreign born, how long in U. S. A.?..... years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 30 year 1940 hour..... minute..... M.

21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....; that I last saw h..... alive on....., 19.....; and that death occurred on the date and hour stated above.

Immediate cause of death Head crushed
automobile accident

Due to.....
passenger in auto.

Due to.....
Carney view and
inguent

Other conditions..... (Include pregnancy within 3 months of death) 7/17/25

Major findings: Of operations Non Callison

Of autopsy.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify).....

(b) Date of occurrence.....

(c) Where did injury occur?..... (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?.....

While at work?..... (Specify type of place) (e) Means of injury.....

23. Signature W. H. Lears (M. D. or other)

Address Bronfield, Mo. Date signed.....

SUPPLEMENTAL

S-18898