

Registration District No. 608

Primary Registration District No. 6807A

Registrar's No. 32

1. PLACE OF DEATH:

(a) County Newton
 (b) City or town Stella, Mo.
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Stella Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 2 days
 In this community Lifetime
 (Specify whether years, months or days)

3. (a) PRINT FULL NAME Nellie (Stansbury) Gentry

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed6. (b) Name of husband or wife Ray Gentry 6. (c) Age of husband or wife if alive dead years7. Birth date of deceased May 3rd 1903
(Month) (Day) (Year)8. AGE: Years 37 Months 1 Days 23 If less than one day
-- hr. -- min.9. Birthplace Newton Co. Missouri
(City, town, or county) (State or foreign country)10. Usual occupation Housework11. Industry or business House12. Name David Stansbury13. Birthplace Newton Co. Missouri
(City, town, or county) (State or foreign country)14. Maiden name Barbara Loftis15. Birthplace Tenn.
(City, town, or county) (State or foreign country)16. (a) Informant Mr. David Stansbury(b) Address Fairview, Missouri17. (a) Burial (b) Date thereof May 28, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Dice Cemetary18. (a) Signature of funeral director Horine-Culver(b) Address Cassville, Missouri19. (a) Aug. 15-1940 Ada Collier
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Newton
 (c) City or town Fairview, Missouri
 (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 26th.
year 1940 hour 8:00 minute P.M.21. I hereby certify that I attended the deceased from May 24, 1940 to May 26, 1940
that I last saw alive on May 26, 1940
and that death occurred on the date and hour stated above.Immediate cause of death Pertussis

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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 Carroll (M. D. or other) _____Address Stella Date signed 5/27/40

Duration

3/21/40

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

REC'D SEP 24 1940

RECEIVED

District Health Officer No. 0,

District File Number 940-2626

Date Filed SEP 18 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 J. C. Canada, Registered Apprentice No. 225, working under my personal supervision.

Signed

Licensed Embalmer No. 3584

P. O. Address Cassville, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

Registration District No. 608

Primary Registration District No. 3807

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

1. PLACE OF DEATH:

(a) County Newton
(b) City or town Stella mo
(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..... (Specify whether
years, months or days)

3. (a) PRINT FULL NAME

Ellie Stansbury Gentry

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex 7 5. Color or race w 6. (a) Single, widowed, married, divorced wid

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 37 Months 1 Days 23 If less than one day hr. min.

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER

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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

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

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

(b) Address.....

19. (a) (Date received local registrar) (b) (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 26 year 1960 hour..... minute..... 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 Peritonitis

Due to.....

Due to.....

Other conditions..... (Include pregnancy within 3 months of death)

Major findings: Of operations.....

Of autopsy.....

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..... (M. D. or other) Address..... Date signed 12/14/60

SUPPLEMENTARY

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

