

o. 2
13-40
17-39
X23159

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

1. PLACE OF DEATH:
(a) County Pettis
(b) City or town Sedalia
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution 703 N. Prospect
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Barbara Lynn Gatewood
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased May 28- 1939
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
1 3 1 hr. min.

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

10. Usual occupation _____
11. Industry or business _____

MOTHER FATHER
12. Name Vigil Eugene Gatewood
13. Birthplace Clinton City Mo.
(City, town, or county) (State or foreign country)
14. Maiden name Grose Sands
15. Birthplace Sedalia Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant V. E. Gatewood
(b) Address Sedalia

17. (a) burial (b) Date thereof Oct 1- 1940
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Crown Hill

18. (a) Signature of funeral director McLaughlin
(b) Address Sedalia

19. (a) 10-1-40 (b) Mrs. HOOKER SANDER
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Pettis
(c) City or town Sedalia
(If outside city or town limits, write "RURAL")
(d) Street No. 703 N. Prospect
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Sept day 29
year 1940 hour 6 minute 30 P. M.

21. I hereby certify that I attended the deceased from Sept 20-
Sept 29- 1940 to Sept 29- 1940
that I last saw her alive on Sept 28- 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Utero Calculus

Due to malnutrition

Due to _____

Other conditions 11/10
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: _____
Of operations _____
Of autopsy _____
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? _____

23. Signature [Signature] (M. D. or other) _____
Address Sedalia Date signed Oct 1- 40

Handwritten notes at the top of the page, possibly including a date like '10-11-40'.

RECEIVED
District Health Officer No. 8
District File Number 10-11-40
Date Filed

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.....

working under my personal supervision.

Registered Apprentice No.....

Signed *P. E. Baker*

Licensed Embalmer No. *2419*

P. O. Address *Sedalia*

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, fact should be so stated above.