S. No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 34356

NOV 12 1940

Registration District No. 999

Primary Registration District No. 1002

Registrar's No. 3872

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

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City Mo. (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Wheatley Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 (Specify whether

In this community unknown years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City, Missouri (If outside city or town limits, write "RURAL")

(d) Street No. 2208 Vine Street (If rural, give location)

(e) If foreign born, how long in U. S. A.? ..... years.

3. (a) PRINT FULL NAME Louis L Gaston Louis L. Gaston

3. (b) If veteran, name war No

3. (c) Social Security No. 523-07-3660

4. Sex Male

5. Color or race Col.

6. (a) Single, widowed, married, divorced Wid.

6. (b) Name of husband or wife Widowed

6. (c) Age of husband or wife if alive ..... years

7. Birth date of deceased Aug (Month) 21 (Day) 1891 (Year)

8. AGE: Years 49 Months 1 Days 11 If less than one day ..... hr. ..... min.

9. Birthplace Kansas (City, town, or county) 1 (State or foreign country)

10. Usual occupation Laborer 1

11. Industry or business 0

FATHER
12. Name Milton Gaston
13. Birthplace Kentucky (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Battie Taylor
15. Birthplace ..... (City, town, or county) Missouri (State or foreign country)

16. (a) Informant Helen Gaston

(b) Address 1703 Olive

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-7-40 (Month) (Day) (Year)

(c) Place: burial or cremation Lincoln Cemetery

18. (a) Signature of funeral director B. L. Graham

(b) Address 2208 Vine Street

19. (a) 10-7-40 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 9-40 year ..... hour ..... minute 4 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 Fracture of the Skull Laceration

Due to Hemorrhage of the Brain

Due to Extra Dural Hemorrhage

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 2 D M

Of autopsy 2 D

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 9-29-40

(c) Where did injury occur? K C Jackson (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Street (Specify type of place)

While at work? yes (e) Means of injury Hit Street Truck

23. Signature [signature] (M. D. or other)

Address [signature] Date signed

(Licensed Embalmer's Statement on Reverse Side)

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 B. L. Graham

Licensed Embalmer No. 2540

P. O. Address 2208 Vine St

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.