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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

7195

State File No. \_\_\_\_\_

Registrar's No. 29

Registration District No. 1240

Primary Registration District No. 5552

48000  
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Little Blue  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Jackson Co. Emergency Hosp  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6 days  
(Specify whether \_\_\_\_\_)

In this community 20 yrs.  
years, months or days

3. (a) PRINT FULL NAME Gates-Elizabeth M.

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 Wid

6. (b) Name of husband or wife Unknown

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

7. Birth date of deceased May 16 1851  
(Month) (Day) (Year)

8. AGE: Years 90 Months 8 Days 26 hr. \_\_\_\_\_ min. \_\_\_\_\_

If less than one day

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

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

12. Name Studebaker, Jan

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

14. Maiden name Jacobs Elizabeth

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

16. (a) Informant J.C. Emery Hosp

(b) Address Little Blue

17. (a) Removal (b) Date thereof 5-19-41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Garnett Mausoleum

18. (a) Signature of funeral director Geo. J. Jones

(b) Address Garnett Mausoleum

19. (a) 2-11-41 (b) Sarah J. Jones  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson

(c) City or town Little Blue  
(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 Feb day 4 year 1941 hour 5:15 minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from Feb 5, 1941, to Feb 11, 1941;

that I last saw her alive on Feb 11, 1941 and that death occurred on the date and hour stated above.

Immediate cause of death Hypostatic terminal pneumonia

Due to fracture of left femur surgical neck

Due to \_\_\_\_\_

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

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 04/8

(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 J. J. Kennedy (M. D. or other) J.M.P.

Address Garnett Co. Hospital Date signed 2/11/41

1954  
49

18

STATE OF VIRGINIA  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS

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 Harold B. Edler

Licensed Embalmer No. 3035

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.

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

7195  
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 5533B  
(b) Township Jamez Primary Registration District No. \_\_\_\_\_ Registered No. \_\_\_\_\_  
City \_\_\_\_\_ (d) Street No. \_\_\_\_\_ St. \_\_\_\_\_  
(If death occurred in Hospital or Institution, write its name instead of street and number)

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.

PRINT FULL NAME Elizabeth N. Gates

(a) Residence, No. \_\_\_\_\_ 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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) W

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) \_\_\_\_\_

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
90 8 26

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. \_\_\_\_\_  
9. Industry or business in which work was done, as saw mill, bank, etc. \_\_\_\_\_  
10. Date 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) \_\_\_\_\_

FATHER 13. NAME \_\_\_\_\_

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

MOTHER 15. MAIDEN NAME \_\_\_\_\_

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

17. INFORMANT (ADDRESS) \_\_\_\_\_

18. BURIAL, CREMATION, OR REMOVAL

PLACE \_\_\_\_\_ DATE \_\_\_\_\_ 19 \_\_\_\_\_

19. FUNERAL DIRECTOR (ADDRESS) \_\_\_\_\_

20. FILED \_\_\_\_\_ 19 \_\_\_\_\_

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 11, 1941

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_ to \_\_\_\_\_, 19 \_\_\_\_\_

I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19 \_\_\_\_\_ Death is said

to have occurred on the date stated above, at \_\_\_\_\_ m.

The principal cause of death and related causes of importance were as follows:

Hypostatic terminal pneumonia  
Fracture of left femur  
Surgical shock  
Date of onset \_\_\_\_\_

Other contributory causes of importance: \_\_\_\_\_

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? Accident Date of injury Feb 4, 1941

Where did injury occur? Home (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury Fall

Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify \_\_\_\_\_

(Signed) J. J. Kennedy, M. D.

(Address) Little Blue, Mo.

Local Registrar.

1 X12241

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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

HOWENA MORE

SUPPLEMENT

J. J. Kennedy Jackson Co 11007 Little Blue Mo

