

No. 2  
13-40  
17-39  
K23159

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **7215**

Registration District No. **404** Primary Registration District No. **5558** Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:  
(a) County **Jackson**  
(b) City or town **Rural - Washington Mo.**  
(c) Name of hospital or institution: **1**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution  (Specify whether)  
In this community **10 yrs**  
years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Missouri** (b) County **Jackson**  
(c) City or town **Rural - Washington**  
(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.?  **0** years

3. (a) PRINT FULL NAME **Francis Charles Gable**  
(b) If veteran, name war **-**  
(c) Social Security No. **Last card**

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **March** day **7<sup>th</sup>**  
year **1941** hour **9** minute **30 A. M.**

4. Sex **Male**  
5. Color or race **white**  
6. (a) Single, widowed, married, divorced **divorced**  
6. (b) Name of husband or wife **Margaret Ann Gable**  
6. (c) Age of husband or wife if alive **22** years  
7. Birth date of deceased **Feb. 5 1911**  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_; that last seen \_\_\_\_\_ and that death occurred on the date and hour stated above.  
Immediate cause of death

8. AGE: Years **30** Months **1** Days **2** If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

**Acute Cerebral Edema**  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

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

10. Usual occupation **Laborer**

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

MOTHER FATHER  
12. Name **Robert Gable**  
13. Birthplace **Kansas**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Minnie Goss**  
15. Birthplace **Pa.**  
(City, town, or county) (State or foreign country)

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.

16. (a) Informant **Mrs. Minnie Gable**  
(b) Address **Grandview, Mo.**

17. (a) **Burial** (b) Date thereof **Mar. 9 1941**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Belton, Mo.**

18. (a) Signature of funeral director **Ray K. Geary, son**  
(b) Address **Grandview, Mo.**

19. (a) **3-19-41** (b) **Moses J. Brennan**  
(Date received local registrar) (Registrar's signature)

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? **21.6**  
(Specify type of place) (e) Means of injury \_\_\_\_\_  
23. Signature **W. J. ...** (M. D. or other) **3**  
Address **1000 ...** Date signed \_\_\_\_\_

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

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**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.....

Licensed Embalmer No.....

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, fact should be so stated above.**

Registration District No. 404

Primary Registration District No. 5558

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH

(a) County Jackson  
(b) City or town Rural  
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson  
(c) City or town Rural  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Francis Charles Grable  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

20. DATE OF DEATH: Month Mar. day 7  
year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

4. Sex M 5. Color or race W  
6. (a) Single, widowed, married, divorced S  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if  
alive \_\_\_\_\_ year  
7. Birth date of deceased: Feb 5 1911  
(Month) (Day) (Year)

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

8. AGE: Years 30 Months 1 Days 2  
If less than one day \_\_\_\_\_ hr \_\_\_\_\_ min.

Immediate cause of death:  
Acute pulmonary Cong.  
gestive + hemorrhage  
Due to Acute Cerebral edema  
Due to Secondary to thymus  
insufficiency; Status thymo-  
lymphaticus

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)  
10. Usual occupation Laborer

Other conditions (include pregnancy within 3 months of death)  
Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
64

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)

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?  
\_\_\_\_\_ (Specify type of place)

16. (a) Informant \_\_\_\_\_  
(b) Address \_\_\_\_\_  
17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation \_\_\_\_\_

While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_  
23. Signature \_\_\_\_\_ (M. D. or other)  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_  
(b) Address \_\_\_\_\_  
19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

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

MOTHER FATHER

SUPPLEMENTARY

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

