

FILED MAY 21 1941

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUSMISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATHState File No. **15444**Registration District No. **668**Primary Registration District No. **3032**Registrar's No. **120**

## 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:  
Bothwell Hospital  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 4 days  
 (Specify whether  
 In this community \_\_\_\_\_  
 years, months or days)

3. (a) PRINT FULL NAME Mal Ruth Gorman3. (b) If veteran, name war ✓ 3. (c) Social Security No. ✓4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced Widow6. (b) Name of husband or wife Claude Gorman 6. (c) Age of husband or wife if alive \_\_\_\_\_ years7. Birth date of deceased May 17 - 1874  
(Month) (Day) (Year)8. AGE: Years 66 Months 10 Days 22 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_9. Birthplace Carrollton, Mo  
(City, town, or county) (State or foreign country)10. Usual occupation Housewife

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

12. Name Herman Swells18. Birthplace Wisconsin  
(City, town, or county) (State or foreign country)14. Maiden name Larah Handy15. Birthplace Wisconsin  
(City, town, or county) (State or foreign country)16. (a) Informant Mrs Lewis Zumatey(b) Address Otterville, Mo17. (a) Burial (b) Date thereof 4-10-41  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Carrollton, Mo18. (a) Signature of funeral director A. F. Parker(b) Address Otterville, Mo19. (a) 4/9/41 (b) Mrs. Harry Sneed  
(Date filed by local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cooper  
 (c) City or town Otterville - R.F. 20  
 (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. 1 years.

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day April  
year 1941 hour 7 minute 50 A.M.21. I hereby certify that I attended the deceased from April 29  
1941 to April 9, 1941  
that I last saw her alive on 4-5, 1941  
and that death occurred on the date and hour stated above.

Immediate cause of death  
Streptococcal infection  
of throat, Parotid and right  
of Kidney } 1. Penicillinization } 10 days  
 2. Parotidectomy }  
 3. Salivary duct ligation }  
 Due to Streptococcal infection

Other conditions none  
(Include pregnancy within 3 months of death)Major findings:  
Of operations noneOf autopsy none

## 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?  
9/15/41

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature Chas D. Osborne (M. D. or other) 11Address Sedalia, Mo Date signed 4/9/41

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

21512

STATEMENT BY LICENSED EMBALMER

RECEIVED  
District Health Officer No. 8,  
District File Number  
5-19-41  
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.....

....., 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, above space should be left blank.

Registration District No. 668

Primary Registration District No. 3033

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

1. PLACE OF DEATH:

- (a) County Jettis
- (b) City or town Bedalia  
(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

- 3. (a) PRINT FULL NAME Mae Ruth Gorman
- 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 wid
- 6. (b) Name of husband or wife \_\_\_\_\_
- 6. (c) Age of husband or wife if alive \_\_\_\_\_ year \_\_\_\_\_ month \_\_\_\_\_ day
- 7. Birth date of deceased (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year) \_\_\_\_\_

8. AGE:	Years	Months	Days	If less than one day
	<u>66</u>	<u>10</u>	<u>22</u>	hr. _____ min. _____

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

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

- 18. (a) Signature of funeral director \_\_\_\_\_
- (b) Address \_\_\_\_\_
- 19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (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) Citizen of foreign country \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: month apr day 9  
year 1947 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: Streptococci infection of tonsil, parotid gland & right kidney N.M.P.

Due to Streptococci infection

Other conditions: No mumps -  
(Include pregnancy within 3 months of death)

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

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) \_\_\_\_\_
  - (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) \_\_\_\_\_ (a) Means of injury \_\_\_\_\_  
23. Signature Chas Osborne (M. D. or other) \_\_\_\_\_  
Address Bedalia Mo Date signed \_\_\_\_\_

SUPPLEMENTARY

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

0960  
1241  
1242  
00

S-15444