

FILLED JUN 13 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 19151

Registration District No. 796

Primary Registration District No. 6039

Registrar's No. 86

9700

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

1. PLACE OF DEATH:

(a) County Saline
(b) City or town Marshall
(If outside city or town limits, write "RURAL" and name of township)
(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 Sept 10
years, months or days

3. (a) PRINT FULL NAME MARIA GAMBLES

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race col 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: Unknown
(Month) (Day) (Year)

8. AGE: Years About 86 Months - Days - If less than one day _____ hr. _____ min.

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

10. Usual occupation FARMER

11. Industry or business _____
MOTHER FATHER { 12. Name Unknown
13. Birthplace 9
(City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant William Bell
(b) Address N. Marshall

17. (a) Burial (b) Date thereof 5-6-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation N. Marshall

18. (a) Signature of funeral director F. D. Ferguson

(b) Address Saline Mo.

19. (a) 5-5-41 (b) Mary Kent
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Saline
(c) City or town Marshall (Rural)
(If outside city or town limits, write "RURAL")
(d) Street No. P.R. 4
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 3rd
year 1941 hour Death Unknown M.

21. I hereby certify that I attended the deceased from April 30
1941, to May 3, 1941;
that I last saw her alive on May 2-41, 1941;
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Apoplexy
Due to Intracranial Hemorrhage

Due to _____
Other conditions g3w
(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?

712 (Specify type of place) _____
While at work? ✓ (e) Means of injury _____

23. Signature W. Madison (M. D. or other) _____
Address Marshall Mo. Date signed 5-5-41

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 6-12-41

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 F. D. Ferguson
Licensed Embalmer No. 2172
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.