

FILLED OCT 13 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 31442

Registration District No. 243

Primary Registration District No. 6334

Registrar's No. _____

1. PLACE OF DEATH:

- (a) County Dallas
 (b) City or town Rural Jackson
 (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 _____
 years, months or days)

3. (a) PRINT FULL NAME

Frank Gilbert3. (b) If veteran,
name war _____

3. (c) Social Security

No. 494-07-97454. Sex MO5. Color or race W6. (a) Single, widowed, married,
divorced M6. (b) Name of husband or wife
Delphia Gilbert6. (c) Age of husband or wife if
alive 39 years7. Birth date of deceased May
(Month)15/885-
(Day) (Year)

8. AGE:

Years

Months

Days

If less than one day

56313

hr. min.

9. Birthplace

Scotland
(City, town, or county)Scotland
(State or foreign country)

10. Usual occupation

Employee Shell Pipe Lin

11. Industry or business

Oiler

12. Name

Unknown

13. Birthplace

"
(City, town, or county)9
(State or foreign country)

14. Maiden name

"
(City, town, or county)9
(State or foreign country)

15. Birthplace

"
(City, town, or county)9
(State or foreign country)

16. (a) Informant

Delphia Gilbert

(b) Address

Buffalo ELKLAND17. (a) ~~Address~~Macadonia
(Burial, cremation, or removal)

(b) Date thereof

8-29-41
(Month) (Day) (Year)

(c) Place: burial or cremation

Macadonia

18. (a) Signature of general director

L. B. James

(b) Address

Buffalo MO19. (a) 9-16-1941

(Date received local registrar)

(b) Wm J. Shewmaker

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 day 28
year 1941 hour 8 minute 30 A.M.21. I hereby certify that I attended the deceased from
8-19- 1941 to 8-28- 1941;
that I last saw him alive on 8-15-41 _____ 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death

Carcinomas of prostate
glands with metastasis
to adjacent structures Unknown

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations NoneOf autopsy None

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)

(e) Means of injury Auto23. Signature G. Plummer (M. D. or other) MDAddress Buffalo MO Date signed 9-4-41

(Licensed Embalmer's Statement on Reverse Side)

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

2
41
-39
X26390

OCT 17 1941

RECEIVED

District Health Officer No. 7,

District File Number 9-41-1706

Date Filed 10-3-41

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

Slyde Montgomery

Licensed Embalmer No.

3592

P. O. Address

Buffalo Ind

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.