

Registration District No. 147

Primary Registration District No. 5310

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Cass
(b) City or town Amal Austin Turp
(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 7 mo.
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Cass
(c) City or town Harrisonville (Rural)
(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.

8. (a) PRINT FULL NAME LETTIE MAE GASTON

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

4. Sex Female 5. Color, of White race 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife A. A. Gaston 6. (c) Age of husband or wife if alive 55 years

7. Birth date of deceased Oct 26 1890
(Month) (Day) (Year)

8. AGE: Years 51 Months - Days 9 If less than one day _____ hr. _____ min.

9. Birthplace Jackson Co Mo. 15
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name J. T. O'Dell

13. Birthplace Ray Co Mo. 11
(City, town, or county) (State or foreign country)

14. Maiden name Chloe A. Armstrong

15. Birthplace Lafayette Co Mo 11
(City, town, or county) (State or foreign country)

16. (a) Informant W. A. Northon

(b) Address Harrisonville Mo

17. (a) burial (b) Date thereof Nov 7 1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Wills Cemetery

18. (a) Signature of funeral director RUNNENBURGER'S

(b) Address HARRISONVILLE, MO

19. (a) Nov 7-41 (b) Mar Donalson
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 4th
year 1941 hour 9:50 minute _____ P. M.

21. I hereby certify that I attended the deceased from Oct-10-41
_____, 1941, to _____, 19____;
that I last saw h. in alive on Nov-2-, 1941.

and that death occurred on the date and hour stated above.
Immediate cause of death Apoplexy

Due to Atherosclerosis 6 years

Due to _____

Other conditions X
(Include pregnancy within 3 months of death)

Major findings: Of operations X

Of autopsy X

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? X
(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 0

23. Signature Frank B Ellis (M. D. or other) _____

Address Garden City Mo Date signed Nov 5 41

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

9
0
0

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 _____

Ernest Rannenburg

Licensed Embalmer No. _____

3368

P. O. Address _____

Harrisonville Mo

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.