20689

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUL 20 1942

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 571

Registration District No. 85 — Primary Registration District No. 1001 — Registrar's No. 633

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

1. PLACE OF DEATH:

(a) County Buchanan,

(b) City or town Saint Joseph, City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 108 North 2nd. Street,
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether
In this community 12 years,
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri, (b) County Buchanan

(c) City or town Saint Joseph,
(If outside city or town limits, write "RURAL")

(d) Street No. 108 North 2nd. Street,
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country .....

3. (a) PRINT FULL NAME John William Gass,

3. (b) If veteran, name war None,

3. (c) Social Security No. 500-09-6876

4. Sex Male

5. Color or race White

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 May 26th. 1883
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
59	1	1	hr. ..... min.

9. Birthplace Buchanan County, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Janitor

11. Industry or business Laundry,

FATHER
12. Name David Gass,
13. Birthplace Unknown, Tennessee
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Martha Lowe,
15. Birthplace Unknown, Indiana
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Pearl Moore
(b) Address 2233 South 9th. Street,

17. (a) Burial (b) Date thereof 6/30/42.
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mount Auburn Cemetery

18. (a) Signature of funeral director Heaton - Wilson & Bowman Funeral Home
(b) Address 319 So. 10th. Street,

19. (a) 6-30-42 (b) Rose Herzog
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 27th.
year 1942. hour 2:00 minute 05p M.

21. I hereby certify that I attended the deceased from June 19, 1942 to June 27, 1942
that I last saw him alive on June 27, 1942
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cardiac Insufficiency	1 yrs
Due to Arteriosclerosis	3 yrs
Due to Paralysis	1 week
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.

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)

While at work? (e) Means of injury

23. Signature Charles H. Werner (M. D. or other)
Address 221 Kirkpatrick Bldg Date signed 6-29-1942

1233 (Licensed Embalmer's Statement on Reverse Side)

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 6-27-42

....., Registered Apprentice No.....

working under my personal supervision.

Signed Wm. E. Summerfield

Licensed Embalmer No. 3007

P. O. Address 319 South St. Joseph M

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

No. 2B
-8-21-41
I X29288

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 20689

Registration District No. 85 Primary Registration District No. 1001 Registrar's No.

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

1. PLACE OF DEATH:
(a) County: Buchanan
(b) City or town: St Joseph
(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 years, months or days)
In this community

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

3. (a) PRINT FULL NAME: John W Gass
3. (b) If veteran, name war
3. (c) Social Security No.

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 years
7. Birth date of deceased: May (Month) 26 (Day) 1883 (Year)

8. AGE: Years 59 Months 1 Days If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
MOTHER FATHER
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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 27 year 1942 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.

	Duration
Immediate cause of death: Paralysis	
Due to: Cerebral Hemorrhage	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations: 430	
Of autopsy	

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

23. Signature Charles H Werner (M. D. or other)
Address St Joseph Mo Date signed Aug 20 1942

SUPPLEMENTARY