. S. No. 2
0M—5-42
ev. 5-17-39
P I X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 7 1944

Registration District No. 7

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 3012

State File No. 17795

Registrar's No. 85

1. PLACE OF DEATH:
(a) County: Clay
(b) City or town: Excelsior Springs
(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: About 52 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo (b) County: Clay
(c) City or town: Excelsior Springs
(If outside city or town limits, write "RURAL")
(d) Street No. 428 South St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country: ____

3. (a) PRINT FULL NAME: Ida Agnes Gaines
3. (b) If veteran, name war: no
3. (c) Social Security No. no
4. Sex: Female
5. Color or race: W
6. (a) Single, widowed, married, divorced: Wd
6. (b) Name of husband or wife: George Gaines
6. (c) Age of husband or wife if alive: 71 years
7. Birth date of deceased: Feb (Month) 2 (Day) 1871 (Year)

8. AGE: Years 73 | Months 3 | Days 27 | If less than one day ____ hr. ____ min.

9. Birthplace: Cass County (City, town, or county) Mo (State or foreign country)
10. Usual occupation: Housewife
11. Industry or business: ____

MOTHER FATHER
12. Name: Chas Cunell
13. Birthplace: Clay Co (City, town, or county) Mo (State or foreign country)
14. Maiden name: Elizabeth Young
15. Birthplace: Illinois (City, town, or county) Ill (State or foreign country)

16. (a) Informant: Geo E Gaines
(b) Address: 1404 Simpson K C Mo RR 6
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 1-31-44 (Month) (Day) (Year)
(c) Place: burial or cremation: Claude Cemetery
18. (a) Signature of funeral director: Claude Cemetery
(b) Address: Excelsior Springs Mo
19. (a) 6-1-44 (Date received local registrar) (b) Mrs Sadie Redmon (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 29 year 1944 hour 1 minute P. M.
21. I hereby certify that I attended the deceased from May 28, 1944 to May 29, 1944 that I last saw her alive on May 29, 1944 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Decompensated Mitral Insufficiency	2 days
Due to: Alcohol Suffered	
Due to: from Chronic Bronchial Asthma.	
Other conditions (Include pregnancy within 3 months of death): Old age	

Major findings:
Of operations: none made
Of autopsy: none made.

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: John F. Greer (M. D. or other) M.D.
Address: Excelsior Springs Mo Date signed 6-1-44

1166

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9
District File Number
Date Filed 6-5-44

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 Earl Ralph

Licensed Embalmer No. 03458

P. O. Address Ex. Springs Mo.

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

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