V. S. No. 2
00M—2-43
ev. 5-17-39
-1 X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 11 1945

STATE BOARD OF HEALTH OF MISSOURI
# STANDARD CERTIFICATE OF DEATH

State File No. 40467

Registration District No. 1 | Primary Registration District No. 3000 | Registrar's No. 3345

**1. PLACE OF DEATH:**
(a) County: Adair
(b) City or town: Kirksville Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: A. S. O. Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 0 (Specify whether years, months or days)
In this community:

**2. USUAL RESIDENCE OF DECEASED:**
(a) State: Mo (b) County: Macon
(c) City or town: New Boston R#1
(If outside city or town limits, write "RURAL")
(d) Street No.:
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country: 1

3. (a) PRINT FULL NAME: MARY ELLEN GALL
3. (b) If veteran, name war:
3. (c) Social Security No.:
4. Sex: F
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: 7 (Month) - 20 (Day) - 1943 (Year)
8. AGE: Years 1 | Months 5 | Days 4 | If less than one day: hr. min.
9. Birthplace: New Boston (City, town, or county) Mo (State or foreign country)
10. Usual occupation:
11. Industry or business:
FATHER 12. Name: Leonard Gall
FATHER 13. Birthplace: New Boston (City, town, or county) Mo (State or foreign country)
MOTHER 14. Maiden name: Celma Gill
MOTHER 15. Birthplace: (City, town, or county) No Dakota (State or foreign country)
16. (a) Informant: Leonard Gall
(b) Address: New Boston Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Dec 26 1944 (Month) (Day) (Year)
(c) Place: burial or cremation: New Boston Cemetery
18. (a) Signature of funeral director: Larson Fun Service
(b) Address: Bucklin Mo
19. (a) 12-26-44 (Date received local registrar) (b) Mrs. J. L. Wagner (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Dec day 24 year 1944 hour 2:30 minute P. M.
21. I hereby certify that I attended the deceased from 12:30 PM Dec. 24, 1944, to 2:30 P.M. Dec 24, 1944; that I last saw him alive on Dec. 24, 1944; and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death: Acute cardiac dilatation | |
| Due to: Bronchial asthma | 24 hours |
| and | |
| Due to: Bronchopneumonia | |
| Other conditions (Include pregnancy within 3 months of death): | |
| Major findings: Of operations: 107 | PHYSICIAN — Underline the cause to which death should be charged statistically. |
| Of autopsy: | |

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: Wm. C. Kelly (M. D. or other) DO
Address: Kirksville, Mo Date signed 12-25-44

1049

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 1-45-78
Date Filed JAN 9 1945

## 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 G. A. Larson

Licensed Embalmer No. 4037

P. O. Address Rockland Me

**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.**