

No. 2
-8-43
5-17-39
1 X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 25 1946
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

37778

State File No. _____
Registrar's No. 245

Registration District No. 294
Primary Registration District No. 3056

1. PLACE OF DEATH:
(a) County Randolph
(b) City or town Proberly
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Mc Cormick Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 17 days
(Specify whether
In this community Entire Life
years, months or days)

3. (a) PRINT FULL NAME JOHN JEFFERSON GAINES
3. (b) If veteran, name war None
3. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Bertha Gaines 6. (c) Age of husband or wife if alive 63 years
7. Birth date of deceased Jan - 1 - 1883
(Month) (Day) (Year)

8. AGE: Years 62 Months 11 Days 8
If less than one day hr. _____ min. _____

9. Birthplace Randolph Co MO
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER
12. Name Phill Gaines 9
13. Birthplace unknown 9
(City, town, or county) (State or foreign country)
14. Maiden name Rogers
15. Birthplace unknown 4
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Frank Sebring
(b) Address 761 Taylor Moberly MO
17. (a) Burial (b) Date thereof Dec 10 - 45
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Oakland Embury

18. (a) Signature of funeral director Snow Funeral Home
(b) Address Proberly Missouri
19. (a) Dec 10 - 45 (b) Deane Wellman
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Randolph
(c) City or town Rural (If outside city or town limits, write "RURAL")
(d) Street No. RFD # 2 (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 8
year 1945 hour 3 minute 40 A.M.
21. I hereby certify that I attended the deceased from Nov. 21, 1945 to Dec 8, 1945
that I last saw him alive on Dec. 8, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death acute endocarditis Duration 16 ds.
Due to Carcinoma of prostate months _____
Due to _____

Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy 5/6

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 P. L. McCormick (M. D. or other M.D.)
Address Moberly mo Date signed 12-8-45

PHYSICIAN
Underline the cause to which death should be charged statistically.

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

100786

RECEIVED

District Health Officer No. 10

District File Number 1-46-111

Date Filed JAN-23-1946

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 R. M. Carter

Licensed Embalmer No. 4117

P.O. Address Moberly 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, fact should be so stated above.