

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED SEP 23 1946**  
STANDARD CERTIFICATE OF DEATH

State File No. **29798**  
Registrar's No. **137**

Registration District No. **59** Primary Registration District No. **4097**

**1. PLACE OF DEATH:**  
(a) County **Cass**  
(b) City or town **Harrisonville**  
(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 **50 years** (Specify whether years, months or days)

**3. (a) PRINT FULL NAME** **Gabriella Anderson**  
**3. (b) If veteran,** name war **✓**  
**3. (c) Social Security** No. **✓**

**4. Sex** **Female** **5. Color or race** **white**  
**6. (a) Single, widowed, married, divorced** **widow**  
**6. (c) Age of husband or wife if alive** **✓** years  
**7. Birth date of deceased** **Feb. 1 1860**  
(Month) (Day) (Year)

**8. AGE:** Years **86** Months **7** Days **14** If less than one day hr. min.

**9. Birthplace** **DeKalb, Mo** **MO**  
(City, town, or county) (State or foreign country)

**10. Usual occupation** **Home maker**

**11. Industry or business**

MOTHER FATHER

**12. Name** **George J. Gallop**  
**13. Birthplace** **Don't know**  
**14. Maiden name** **Elizabeth Alvar**  
**15. Birthplace** **Don't know**  
(City, town, or county) (State or foreign country)

**16. (a) Informant** **Mrs. Anna Keith**  
**(b) Address** **Harrisonville, Mo**  
**17. (a) Burial** **(b) Date thereof** **Sept 16, 1946**  
(Burial, cremation, or removal) (Month) (Day) (Year)

**(c) Place: burial or cremation** **Orient**  
**18. (a) Signature of funeral director** **HUNNENBURGER'S**  
**(b) Address** **HARRISONVILLE, MO.**  
**19. (a) 9-16-1946** **(b) Laura J. Jones**  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**  
(a) State **Mo** (b) County **Cass**  
(c) City or town **Harrisonville**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **0**  
(If rural, give location)  
(e) Citizen of foreign country? **✓** (Yes or No)  
If yes, name country **✓**

**MEDICAL CERTIFICATION**  
**20. DATE OF DEATH:** Month **Sept.** day **15** year **1946** hour **12** minute **30 A.M.**  
**21. I hereby certify that I attended the deceased from** **Sept 12 - 46**  
**21** **19** **15** **1946**  
that I last saw **or** alive on **Sept 14** **1946**  
and that death occurred on the date and hour stated above.

**Immediate cause of death** **Coronary Heart Disease**  
**Acute chronic nephritis**  
**Due to** \_\_\_\_\_

**Due to** \_\_\_\_\_

**Other conditions** \_\_\_\_\_  
(Include pregnancy within 3 months of death)

**Major findings:**  
**Of operations** \_\_\_\_\_  
**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?

**23. Signature** **J. M. Scott** **(M. D. or other)**  
**Address** **Harrisonville, Mo** **Date signed** **9/15/46**  
While at work \_\_\_\_\_ (Specify type of place) (c) Means of injury \_\_\_\_\_

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

JUL 14 1947

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 R. Remminger

Licensed Embalmer No. 3368

P. O. Address Harrisonville

**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.

Registration District No. 59 Primary Registration District No. 4097

**1. PLACE OF DEATH:**  
(a) County Case Harrison  
(b) City or town Case Harrison  
(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 \_\_\_\_\_)

In this community \_\_\_\_\_ years, months or days)  
**3. (a) PRINT FULL NAME** Gabriella S. Anderson  
**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** wid

**6. (b) Name of husband or wife** \_\_\_\_\_ **6. (c) Age of husband or wife if alive** \_\_\_\_\_  
**7. Birth date of deceased** Feb 1 (Month) (Day) (Year)

**8. AGE:** Years 86 Months 7 Days \_\_\_\_\_ (Unless than one day)  
hr. \_\_\_\_\_ min. \_\_\_\_\_

**9. Birthplace** Detrol (City, town, or county) Mo. (State or foreign country)

**10. Usual occupation** \_\_\_\_\_

**11. Industry or business** \_\_\_\_\_

**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)** \_\_\_\_\_ **(b) Date thereof** \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)  
**(c) Place: burial or cremation** \_\_\_\_\_

**18. (a) Signature of funeral director** \_\_\_\_\_  
**(b) Address** \_\_\_\_\_

**19. (a)** \_\_\_\_\_ (Date received local registrar) Laura J. Jones (Registrar's signature)

**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 \_\_\_\_\_

**MEDICAL CERTIFICATION**  
**20. DATE OF DEATH:** Month \_\_\_\_\_ year 1986 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
**21. I hereby certify that I attended the deceased from** \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
Duration \_\_\_\_\_

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)  
**PHYSICIAN** \_\_\_\_\_

**Major findings:**  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
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? \_\_\_\_\_

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

**23. Signature** \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
**Date signed** \_\_\_\_\_

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

SUPPLEMENTARY

29798