

Registration District No. 290

Primary Registration District No. 4427

Registrar's No. 63

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Weyersville  
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo County Texas<sup>107</sup>

(c) City or town Rural<sup>0</sup>  
(If outside city or town limits, write "RURAL")

(d) Street No. TW of Hartshorne Mo<sup>0</sup>  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)  
If yes, name country.....

3. (a) PRINT FULL NAME Odis Delmar Gale

3. (b) If veteran, name war ✓

3. (c) Social Security No. 500-05-6082

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 10  
year 1947 hour..... minute..... M.

4. Sex Mo 5. Color or race W

6. (a) Name of husband or wife Agnes Gale

6. (c) Age of husband or wife if alive 52 years

7. Birth date of deceased July 1890  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from May 10, 1947 to....., 19.....  
that I last saw h..... alive on....., 19.....  
and that death occurred on the date and hour stated above.

8. AGE: Years 57 Months 4 Days..... hr..... min.....  
If less than one day

9. Birthplace Texas Co. Mo<sup>0</sup>  
(City, town, or county) (State or foreign country)

Immediate cause of death.....  
Hit by car & had  
3-hr  
fractured by head  
injury & shock

Due to.....

Due to.....

Other conditions.....  
(Include pregnancy within 3 months of death)

10. Usual occupation FARMING

11. Industry or business.....

12. Name Jake Gale

13. Birthplace Texas Co. Mo<sup>0</sup>  
(City, town, or county) (State or foreign country)

14. Maiden name Elvira Starks

15. Birthplace Texas Co. Mo<sup>0</sup>  
(City, town, or county) (State or foreign country)

Major findings:  
Of operations.....  
Of autopsy.....

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

16. (a) Informant Agnes Gale

(b) Address Hartshorne Mo

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

(c) Place: burial or cremation Hartshorne

18. (a) Signature of funeral director Smith Ferguson

(b) Address Licking Mo

19. (a) 5/31/47 (b) Thelma C. Buckhops  
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)..... 107

(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 Licking (M. D. or other) MD  
Address Licking Mo Date signed.....

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

MOTHER, FATHER

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**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 *Embert E. Ferguson*  
Licensed Embalmer No. *3945*  
P. O. Address *Licking 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.**