

Rhodes

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

FILED AUG 5 1947

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 23239

Registration District No. _____

Primary Registration District No. 3000

Registrar's No. 205

1. PLACE OF DEATH:

(a) County Adair
(b) City or town Kingsville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 402 S. Osteopathy St. /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. 3 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Adair
(c) City or town Kingsville
(If outside city or town limits, write "RURAL")
(d) Street No. 402 S. Osteopathy St.
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country: _____

3. (a) PRINT FULL NAME Nancy Ellen Gay

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 Widowed
6. (b) Name of husband or wife William Gay 6. (c) Age of husband or wife if alive ✓ years
7. Birth date of deceased September 16 1871
(Month) (Day) (Year)

8. AGE: Years 75 Months 10 Days 1 If less than one day .hr. min.

9. Birthplace DAVIS CO. IA. /
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

MOTHER FATHER { 12. Name THOMAS COONS
13. Birthplace D.K. IND. /
(City, town, or county) (State or foreign country)
14. Maiden name L. Genda Hochreasmith
15. Birthplace D.K. IND. /
(City, town, or county) (State or foreign country)

16. (a) Informant Roy Gay
(b) Address Atkins, Mo.

17. (a) Burial (b) Date thereof 7-20-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Nex Hamney Cemetery

18. (a) Signature of funeral director Davis & General Ham
(b) Address Kingsville Mo.

19. (a) 8-1-47 (b) Kate Lambert
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 18th
year 1947 hour Eight minute 25 P. M.

21. I hereby certify that I attended the deceased from July 18
1947 to July 18 1947
that I last saw her alive on July 18 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage
Due to Hypertension ?

Other conditions g p
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations: _____
Of autopsy: _____

Duration
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?

While at work? _____ (Specify type of place)
Means of injury _____

23. Signature J. T. Rhodes (M.D. or other) J. T.
Address Kingsville, Mo Date signed 8-1-47

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

RECEIVED
District Health Officer No. 10
District File No. 8-47-981
Date Filed AUG - 4 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, ~~only~~.....

working under my personal supervision.

Registered Apprentice No.

Signed Clarence M. Billo.....

Licensed Embalmer No. 9325.....

P. O. Address Beeksville, Md.....

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.