

FILED OCT 25 1947

Registration District No. 71

Primary Registration District No. 3012

Registrar's No. 156

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

1. PLACE OF DEATH:

(a) County Clay

(b) City or town Excelsior Springs, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Veterans Administration Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 8 mos. 18 days
(Specify whether years, months or days)

In this community 8 mos. 18 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Pike

(c) City or town Louisiana
(If outside city or town limits, write "RURAL")

(d) Street No. Box 257
(If rural, give location)

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

3. (a) PRINT FULL NAME Robert E. Gaw

3. (b) If veteran, name war World War II

3. (c) Social Security No. 557284999

4. Sex Male 5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Mrs. Edna Gaw

6. (c) Age of husband or wife if alive 39 years

7. Birth date of deceased March 9 1912
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

35 7 0 hr. min.

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

10. Usual occupation Laborer

11. Industry or business "

12. Name Unknown Ernie Gaw

13. Birthplace Illinois (City, town, or county) (State or foreign country)

14. Maiden name Carrie Gaw Browning

15. Birthplace Edgewood Missouri (City, town, or county) (State or foreign country)

16. (a) Informant Hospital Records, Veterans Administration

(b) Address Excelsior Springs, Mo.

17. (a) Removal of removal (b) Date thereof 10-9-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: Bowling Green, Mo.

18. (a) Signature of funeral director Charles Hope
Hope Funeral Home

(b) Address Excelsior Springs, Mo.

19. (a) 10-9-47 (b) Barbara Nutchings
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8th day October
year 1947 hour 5:15 minute P. M.

21. I hereby certify that I attended the deceased from January 20, 1947, to October 8, 1947,
that I last saw him alive on October 8, 1947,
and that death occurred on the date and hour registered above.

Immediate cause of death Tuberculosis, pulmonary, reinfection unknown type far advanced, active

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 13 B

Of autopsy No autopsy performed

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? S. C. Street (Specify type of place) (or) Means of injury --

23. Signature S. C. Street (M. D. or other) MD
Address Veterans Administration Hospital, Excelsior Springs, Mo. Date signed 10-9-47

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed _____

10-24-47

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 _____

J. A. Moles

Licensed Embalmer No. _____

3296

P. O. Address _____

Epeluis Springs, N.C.

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.