

S. No. 2
M-5-43
5-17-39
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **37816**
Registrar's No. **1008**

FILED DEC 15 1947 **28**
Registration District No. _____

Primary Registration District No. **5466**

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

1. PLACE OF DEATH:
 (a) County **GREENE**
 (b) City or town **Rural - S. Campbell Twp.**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
OZARK OSTEOPATHIC HOSPITAL
(If not in hospital or institution, write street number of house)
 (d) Length of stay: In hospital or institution _____ (Specify whether years, months or days) **two days**

3. (a) PRINT FULL NAME **WILLIAM GASKINGS**
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **Male** 5. Color or race **White**
 6. (a) Single, widowed, married, divorced **MARRIED**
 6. (b) Name of husband or wife **BETTY GASKINGS.** 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased **MARCH 15 1884**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
63 8 8 hr. min.

9. Birthplace **Springfield, Ill**
(City, town, or county) (State or foreign country)
 10. Usual occupation **rail road Conductor**

11. Industry or business _____
 12. Name **Harry Gaskings**
 13. Birthplace **unknown**
(City, town, or county) (State or foreign country)
 14. Maiden name **Margaret**
 15. Birthplace **unknown**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Betty Gaskings**
 (b) Address **Star Rr., Brandon Mo.**
 17. (a) **Removal** (Burial, cremation, or removal) (b) Date thereof **11-23-47**
(Month) (Day) (Year)
 (c) Place: burial or cremation **Olson Iowa**

18. (a) Signature of funeral director **R. O. Whelchel**
 (b) Address **Brandon Mo**
 19. (a) **11-23-47** (Date received local registrar) (b) **W. J. Deedley Mo** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Iowa** (b) County **Waubesa**
 (c) City or town **Eldon** **999**
(If outside city or town limits, write "RURAL")
 (d) Street No. **13**
(If rural, give location)
 (e) Citizen of foreign country? **no** (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **11** day **23**
 year **1947** hour **2** minute **10 P.M.**
 21. I hereby certify that I attended the deceased from **11-21-1947** to **11-23-1947**
 that I last saw him alive on **11-23-1947** and that death occurred on the date and hour stated above.

Immediate cause of death **Congestive Heart failure**
 Due to _____
 Due to _____
 Other conditions (Include pregnancy within 3 months of death) _____
 Major findings: Of operations _____
 Of autopsy _____
 Duration _____

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 **William J. Vogel** (M. D. or other) **MD**
 Address **Springfield Mo** Date signed **11-23-47**

OCT 21 1948

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... *Minnie L. Pachel*

Licensed Embalmer No. *2277*

P. O. Address *Dunsmuir*

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.