

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 2112

BIRTH NO. _____ REG. DIST. NO. 274 PRIMARY REG. DIST. NO. 3052 Registrar's No. 30

1. PLACE OF DEATH a. COUNTY <u>PETTIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Pettis</u>	
b. CITY (If outside corporate limits, write RURAL and give town) <u>SEDALIA</u> c. LENGTH OF STAY (in this place) <u>Lifetime</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Sedalia</u>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>Bothwell Memorial Hospital</u>		d. STREET ADDRESS (If rural, give location) <u>415 West 7th</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>MINNIE</u>	b. (Middle)	c. (Last) <u>GENTRY</u>	4. DATE OF DEATH (Month) (Day) (Year)
				<u>Jan 23 1949</u>

5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Sept. 20 1869</u>	9. AGE (In years last birthday) <u>79</u>	IF UNDER 1 YEAR Months	IF UNDER 2 HRS. Hours	IF UNDER 15 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Chicago, Ill.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>Charles Godschalk</u>	13b. MOTHER'S MAIDEN NAME <u>Belle Kellerman</u>	14. NAME OF HUSBAND OR WIFE <u>Chas. C. Gentry</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, enter unknown) (If yes, give war or dates of service) <u>NO</u>	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Charles W. Gentry</u>	ADDRESS <u>Rt.#3 Sedalia, Mo</u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) <u>Left Cerebral Hemorrhage</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic Heart Disease</u> <u>Essential Hypertension</u> DUE TO (c) <u>Secondary Anemia.</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>no</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 19 Jan 1949 to 23 Jan 1949, that I last saw the deceased alive on 23 Jan 1949, and that death occurred at 4:40 P.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Paul Siegel M.D.</u>	23b. ADDRESS <u>115 1/2 East Fourth St. Sedalia, Mo</u>	23c. DATE SIGNED <u>1/24/49</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Jan 25 1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Crown Hill Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Sedalia, Missouri</u>
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DATE REC'D BY LOCAL REG. <u>Jan. 25, 1949</u>	REGISTRAR'S SIGNATURE <u>Betty Yeager Deputy</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Al W. Hechart</u>	ADDRESS <u>Sedalia, Mo</u>
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(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY--USING UNFADING BLACK INK--MAKE A PERMANENT RECORD

Handwritten: Paul Siegel M.D. 10 1949

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed 2-9-49

FEB 6 1950

FEB 11 1950

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed *W. Beckhart*

Signed _____
Student Embalmer

Licensed Embalmer No. 3470

P. O. Address Sedalia, 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.