

FILED MAR 11 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 5743

BIRTH NO. _____ REG. DIST. NO. 282 PRIMARY REG. DIST. NO. 3055 Registrar's No. 33

1. PLACE OF DEATH a. COUNTY Polk			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY Polk		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Bolivar		c. LENGTH OF STAY (in this place)	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Bolivar		
d. FULL NAME OF HOSPITAL OR INSTITUTION			d. STREET ADDRESS (If rural, give location)		

3. NAME OF DECEASED (Type or Print) a. (First) Emma b. (Middle) Elizabeth c. (Last) Gentry			4. DATE OF DEATH (Month) (Day) (Year) Feb. 27 1950		
5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH Dec. 31, 1866	9. AGE (In years last birthday) 83	IF UNDER 1 YEAR Months
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Davis County Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Elisha F. Martin	13b. MOTHER'S MAIDEN NAME Rebecca Taffee	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME Mrs. Minnie Kackley	ADDRESS Trenton, Mo.
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 332X
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Medullary Failure		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Thrombotic Encephaloma DUE TO (c) Arterio sclerosis		
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 type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from _____, 1947 to **Feb. 27 1950**, that I last saw the deceased alive on **Feb. 27, 1950**, and that death occurred at **9:10 pm.**, from the causes and on the date stated above.

23a. SIGNATURE M. J. Gumbert, M.D.	23b. ADDRESS Bolivar Missouri	23c. DATE SIGNED Feb. 28, 1950
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24a. BURIAL, CREMATION, REMOVAL (Specify) burial	24b. DATE Mar. 1, 1950	24c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery	24d. LOCATION (City, town, or county) (State) Bolivar, Mo.
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DATE REC'D BY LOCAL REG. Feb 28, 1950	REGISTRAR'S SIGNATURE Ralph Gorden per Jewell Gorden	25. FUNERAL DIRECTOR'S SIGNATURE Turpin Funeral Home	ADDRESS Bolivar, Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

0841

5841

MAR 28 1950

RECEIVED

District Health Officer No. 7,

District File Number 2-50-194

Date Filed 3-10-50

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.

Student _____
Student Embalmer

Signed _____

Licensed Embalmer No. 3053

P. O. Address Bolivar, 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.