

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED AUG 21 1950

State File No. **26065**

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 922

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Gentry	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Gentry	
d. FULL NAME OF HOSPITAL OR INSTITUTION Missouri Methodist Hospital		d. STREET ADDRESS (If rural, give location)	

3. NAME OF DECEASED (Type or Print)	a. (First) Anna	b. (Middle)	c. (Last) Gabriel	4. DATE OF DEATH (Month) (Day) (Year) August 11, 1950
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5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH March 8, 1897	9. AGE (In years last birthday) (Months) (Days) (Hours) (Min.) 53 5 3	10. IF UNDER 1 YEAR	11. IF UNDER 1 HRS.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home	10b. KIND OF BUSINESS OR INDUSTRY at home	11. BIRTHPLACE (State or foreign country) Worth County, Missouri	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME John Danner	13b. MOTHER'S MAIDEN NAME Clare Jones	14. NAME OF HUSBAND OR WIFE David L. Gabriel
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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 Keith Gabriel, Albany, Missouri	ADDRESS
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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 157A
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Disease of liver + gall bladder		
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
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 None.	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)
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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?
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22. I hereby certify that I attended the deceased from Aug 11, 1950, to Aug 5, 1950, that I last saw the deceased alive on Aug 2, 1950, and that death occurred at 9:30 P. m., from the causes and on the date stated above.

23a. SIGNATURE Paul Jones MD	(Degree or title)	23b. ADDRESS St. Joseph, Mo	23c. DATE SIGNED 8-13-50
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 8/11/50	24c. NAME OF CEMETERY OR CREMATORY -----	24d. LOCATION (City, town, or county) (State) Albany, Missouri
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DATE REC'D BY LOCAL REG. 8-15-50	REGISTRAR'S SIGNATURE B. B. Jenkins	382	FUNERAL DIRECTOR'S SIGNATURE Heater-Bruman Funeral Home	ADDRESS St. Joseph, Mo.
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(Licensed Embalmer's Statement on Reverse Side)

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

No. 300
10.48
17
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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

20331

working under my personal supervision.

Student Embalmer No.....

Signed

Jane B. Hawkins

Signed.....
Student Embalmer

Licensed Embalmer No. 4531

P. O. Address 368 E. 10 St. J. G.

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.