

S. No. 300  
V. 10-48

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **41803**

FILED JAN 9 1953

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 71 PRIMARY REG. DIST. NO. 3012 Registrar's No. 173

0242  
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1. PLACE OF DEATH a. COUNTY <u>Clay</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Clay</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Excelsior Springs</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Excelsior Springs</u> <u>0242</u>	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) <u>809 St. Louis Avenue</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>809 St. Louis Avenue</u>			

3. NAME OF DECEASED (Type or Print) <u>MARGARET</u>	a. (First)	b. (Middle) <u>GAINES</u>	c. (Last) <u>DOUGLAS</u>	4. DATE OF DEATH <u>Dec. 31, 1952</u>
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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>Feb. 18, 1867</u>	9. AGE (In years last birthday) <u>85</u>	IF UNDER 1 YEAR Months <u>10</u> Days <u>13</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>John W. Gaines</u>	13b. MOTHER'S MAIDEN NAME <u>Rebecca (Unknown)</u>	14. NAME OF HUSBAND OR WIFE <u>Millard Douglas</u>
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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) <u>no</u>	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mabel Davis</u>	ADDRESS <u>809 St. Louis Ave. Excelsior Springs, Mo.</u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary thrombosis</u>		DUE TO (b) <u>arteriosclerosis</u>		<u>instant</u>
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS. Conditions contributing to the death but not related to the disease or condition causing death. <u>Umbilical hernia</u>				

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)	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 4/7, 1948, to Dec. 31, 1952 that I last saw the deceased alive on Dec. 31, 1952, and that death occurred at 2:00 p.m., from the causes and on the date stated above.

23a. SIGNATURE <u>M. D. Excelsior Springs, Mo.</u>	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED <u>12/31/52</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>1-3-53</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Shady Grove Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Rural, Kearney, Mo.</u>
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DATE REC'D BY LOCAL REG. <u>1-3-53</u>	REGISTRAR'S SIGNATURE <u>Caroline Hutchings</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Charles Richard</u>	ADDRESS <u>Exc. Springs, Mo.</u>
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(Licensed Embalmer's Statement on Reverse Side)

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

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

*Lindell K. Jarman*

Licensed Embalmer No. *4589*

P. O. Address *Excelsior Springs, 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.