

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED APR 15 1954

BIRTH NO. _____ REG. DIST. NO. 157 PRIMARY REG. DIST. NO. 3028 Registrar's No. 78

1. PLACE OF DEATH a. COUNTY <u>Gasper</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>Gasper</u> <u>MO90</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Carthage Mo</u>		c. LENGTH OF STAY (In this place) <u>2 da</u>	c. CITY OR TOWN <u>Sarcovie Mo</u>
d. FULL NAME OF (If not in hospital or institution, give street address or location) <u>McLure Brooks Hosp</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
e. STREET ADDRESS (If rural, give location) <u>Rt 2 Sarcovie Twp</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Perry E</u> b. (Middle) <u>Gasper</u> c. (Last) <u>Person</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>3-24-54</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>7-2-1888</u>
9. AGE (In years last birthday) <u>65</u>		10. USUAL OCCUPATION (Give kind of work; do not state most of working life, even if retired) <u>Farmer</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Gasper Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>

13a. FATHER'S NAME <u>John Gasper</u>	13b. MOTHER'S MAIDEN NAME <u>unknown</u>	14. NAME OF HUSBAND OR WIFE <u>Laure Gasper</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give way or dates of service) <u>None</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Laure Gasper Sarcovie Mo</u>
		ADDRESS <u>Sarcovie Mo</u>

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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Hemorrhage, intestinal</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>
	ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>5 days</u>		
	DUE TO (c) <u>Peptic Ulcer</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>unknown</u>			

19a. DATE OF OPERATION <u>none</u>	19b. MAJOR FINDINGS OF OPERATION <u>5400</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>none</u>	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)	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 Mar 22, 1954, to Mar 24, 1954, that I last saw the deceased alive on Mar 23, 1954, and that death occurred at 6:30 a.m. from the causes and on the date stated above.

23a. SIGNATURE <u>George E. Ward MD</u>	(Degree or title)	23b. ADDRESS <u>Carthage Mo</u>	23c. DATE SIGNED <u>3/27/54</u>
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24a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>3-28-54</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Red Oak Cem</u>	24d. LOCATION (City, town, or county) (State) <u>Maple Grove Mo</u>
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DATE REC'D BY LOCAL REG. <u>4-7-54</u>	REGISTRAR'S SIGNATURE <u>Walter B. Clinton MD</u>	139-0	25. FUNERAL DIRECTOR'S SIGNATURE <u>Jackson Sons Sarcovie Mo</u>	ADDRESS
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED APR 14 1954
Jasper County Health Office
County File Number 54-4-29
Date Filed APR 14 1954

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. 11
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Wm K Jackson*
Licensed Embalmer No. 395
P. O. Address *Savannah*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.