

FILED AUG 24 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 26980

BIRTH NO. _____		REG. DIST. NO. <u>209</u>		PRIMARY REG. DIST. NO. <u>3043</u>		Registrar's No. <u>242</u>	
1. PLACE OF DEATH a. COUNTY <u>Marion</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Shelby</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Hannibal</u>		c. LENGTH OF STAY (in this place) <u>4 Days</u>		c. CITY OR TOWN <u>Shelbyville</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>St. Elizabeth Hospital</u>				STREET ADDRESS (If rural, give location) _____			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Herbert</u>			b. (Middle) <u>Preston</u>		c. (Last) <u>Gaines</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Aug. 8, 1955</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>June 25, 1888</u>		9. AGE (In years last birthday) <u>67</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hour _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Probate Judge</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Shelby County</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Shelby County, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Samuel Adrian Gaines</u>			13b. MOTHER'S MAIDEN NAME <u>Susan Ellen Perry</u>		14. NAME OF HUSBAND'S WIFE <u>Bessie Lee Gaines</u>		
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>498-34-9106</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. H. P. Gaines, Shelbyville, 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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary thrombosis</u>					INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
	ANTECEDENT CAUSES Morbid 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 _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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) (m.) _____		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 <u>8-5-55</u> , 19 <u> </u> , to <u>8-8-55</u> , 19 <u> </u> , that I last saw the deceased alive on <u>8-8-55</u> , 19 <u> </u> , and that death occurred at <u>12</u> P. M., from the causes and on the date stated above.							
23a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>0 M.D.</u>				23b. ADDRESS <u>100 N. Sixth, Hannibal, Mo.</u>		23c. DATE SIGNED <u>8-13-55</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>8/10/1955</u>	24c. NAME OF CEMETERY OR CREMATORY <u>IOOF Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Shelbyville, Mo.</u>		
DATE REC'D BY LOCAL REG. <u>8-17-55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>[Signature] Shelbyville, Mo.</u>		

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

RECEIVED AUG 23 1955
MARION CO. HEALTH DEPT.
DATE FILED AUG 23 1955

MAY 15 1956

AUG 26 1955

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.....
Signature of Student Embalmer

Signed..... *Paul E. Hayes*

Licensed Embalmer No. 4461

P. O. Address..... Shelbina,

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.