

pt. Health,  
, & Welfare  
S. Public  
alth Service

V. S. 300  
ev. 1-57  
0930

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.  
All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

STANDARD CERTIFICATE OF DEATH

FILED MAR 25 1958

47750 STATE FILE NUMBER

Registration District No. 314 Primary Registration District No. 4437 Registrar's No. 19

1. PLACE OF DEATH a. COUNTY <b>St. Clair</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Clair</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Lowry City Butler</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Lowry City</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Butler Township</b>		Length of stay in lb	d. STREET ADDRESS <b>Butler Township</b> (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Allen</b> Middle <b>S.</b> Last <b>Gambill</b>			4. DATE OF DEATH Month <b>Nov</b> ; Day <b>8</b> ; Year <b>1957</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-9-1868</b>	9. AGE (In years last birthday) <b>89</b>	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired - Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Dade County Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13a. FATHER'S NAME <b>John Gambill</b>		13b. MOTHER'S MAIDEN NAME <b>Adrona Barnell</b>		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Fay Lyons, Lowry City Missouri</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cerebral hemorrhage.</b>				INTERVAL BETWEEN ONSET AND DEATH <b>minimal</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>hypertension -</b>					
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <b>1953</b> to <b>11-8-57</b> and last saw him alive on <b>Sept 8, 57</b> Death occurred <b>Lowry City Mo; Nov 8, 1957</b> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>Ruth Seavers MD</b> (Degree or title)			22b. ADDRESS <b>Osceola Mo.</b>		22c. DATE SIGNED <b>3-24-58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>11/10/57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Pleasant Mound</b>		23d. LOCATION (City, town, or county) (State) <b>Osceola Missouri</b>
24. FUNERAL DIRECTOR <b>Emmanuel Johnson</b>		ADDRESS	25. DATE RECD. BY LOCAL REG. <b>3-14-58</b>		26. REGISTRAR'S SIGNATURE <b>Ruth Seavers</b>

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 *J B [Signature]* .....

Licensed Embalmer No. 3038 .....

P. O. Address *Orceola, Va* .....

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.