

RL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-004673

FILED VS FEB 1 1960

Registration District No. 324 Primary Registration District No. 30720 Registrar's No. 18 STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY <u>Saline</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Saline</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Marshall</u>		Length of stay in 1b <u>37 yrs.</u>		c. CITY OR TOWN <u>Marshall</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>953 W Vest</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>953 W Vest</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>OLIVENA</u> Middle <u>PEARL</u> Last <u>GABERT</u>				4. DATE OF DEATH Month <u>January</u> Day <u>29</u> Year <u>1960</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>9-8-1890</u>		9. AGE (last birthday) <u>69</u> IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (City and state or country) <u>Line Co, Nevada</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>		
13a. FATHER'S NAME <u>Joseph Laughlin</u>			13b. MOTHER'S MAIDEN NAME <u>Margarett Hayes</u>			14. NAME OF HUSBAND OR WIFE <u>Frank Gabert</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>no</u>		17. INFORMANT Address <u>Frank Gabert 953 W Vest Marshall</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Anoxia</u>								INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Pulmonary Metastasis</u>								<u>2 mo.</u>	
DUE TO (c) <u>Case of Bowel & Liver</u>								<u>6 mo.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> N: <input type="checkbox"/> Unknown			
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 <u>1:15 p.m.</u> Month, Day, Year		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 <u>Oct 1959</u> to <u>Jan 29, 1960</u> and last saw him alive on <u>Jan 29, 1960</u> . Death occurred at <u>1:15 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <u>Dr. Kujalaud M.D.</u>				22b. ADDRESS <u>Marshall, Missouri</u>				22c. DATE SIGNED <u>1/30/60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>1-31-1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Sunset Memorial Cemetery</u>			23d. LOCATION (City, town, or county) (State) <u>Marshall, Missouri</u>		
24. FUNERAL DIRECTOR ADDRESS <u>Sweeney-Reser Funeral Home, Marshall 1-30-60</u>				25. DATE RECD. BY LOCAL REG.		26. REGISTRAR'S SIGNATURE <u>Cecil G. Read</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

0961 0 8 NMP

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Jack M. Reese

Licensed Embalmer No. 4643
P. O. Address Muskogee

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.