

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

26514

1. PLACE OF DEATH

County Buchanan
Township St. Joseph,
City St. Joseph, (No. Missouri Methodist Hospital)

Registration District No. 85
Primary Registration District No. 1001

File No. _____
Registered No. 914
St. _____ Ward _____

2. FULL NAME

Celia Ann Gauntt

(a) Residence. No. _____ St. _____ Ward. Savannah, Mo.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF James Gauntt,

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct. 12, 1897

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>29</u>	<u>10</u>	<u>25</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home,
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Saline County,
(STATE OR COUNTRY) Missouri,

10. NAME OF FATHER David Johnson,

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Unknown,
(STATE OR COUNTRY) Illinois,

12. MAIDEN NAME OF MOTHER Hettie Hess,

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Whitesville,
(STATE OR COUNTRY) Missouri,

14. INFORMANT James Gauntt
(Address) Savannah, Missouri.

15. FILED 8 1927
John G. Wh
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 27 1927
17. _____

I HEREBY CERTIFY, That I attended deceased from Sept 6, 1927, to 7-Sept, 1927, that I last saw h. alive on Sept 7, 1927, and that death occurred, on the date stated above, at 9 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cervical Fibroma (Multiple)

48 53E (duration) 2 years possibly
CONTRIBUTORY Hemorrhage occurring every 10 days or so weak and at time of and following operation
(SECONDARY) (duration) _____ yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH. Savannah Mo

1 DID AN OPERATION PRECEDE DEATH? yes DATE OF Sept 7-27

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Operation & Clinical
(Signed) W. E. G. M. D.
, 19 (Address) St. Joseph Mo

*State the DISEASE CAUSING DEATH, in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Savannah Cemetery DATE OF BURIAL Sept. 9, 19 27

20. UNDERTAKER Theaton-Birkale Und Co. ADDRESS 319 S. 10 St.
by J. H. K. K. K.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

T 27 1927

EXACTLY. PHYSICIAN'S
Race the of of
is the

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Buchanan Registration District No. 85 File No. _____
 Township _____ Primary Registration District No. 1001 Registered No. 914
 City St. Joseph (No. _____) St. _____ Ward _____

2. FULL NAME

Celia Ann Gauntt
 (a) Residence No. _____ St. _____ Ward _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>F</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>M</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) _____		
7. AGE	YEARS	MONTHS
		DAYS
	If LESS than 1 day, _____ hrs. or _____ min.	
8. OCCUPATION OF DECEASED		
(a) Trade, profession, or particular kind of work _____		
(b) General nature of industry, business, or establishment in which employed (or employer) _____		
(c) Name of employer _____		
9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) _____		

PARENTS	10. NAME OF FATHER _____
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) _____
	12. MAIDEN NAME OF MOTHER _____
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

14. INFORMANT (Address) _____

15. FILED 11/12, 1927 John S. White REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 7 1927

17. I HEREBY CERTIFY, That I attended deceased from _____ to _____, 19____, that I last saw him _____, and that death occurred, on the date stated above, at _____.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cervical fibrosarcoma
multiple, carcinomatous
 (duration) _____ yrs. _____ mos. _____ da.
 CONTRIBUTORY Hemorrhage occurring every
 (SECONDARY) 10 days or so weeks one at time & following
 (duration) operation _____ yrs. _____ mos. _____ da.

18. WHERE WAS DISEASE CONTRACTED _____
 IF NOT AT PLACE OF DEATH, _____
 DID AN OPERATION PRECEDE DEATH? 11/6 DATE OF _____
 WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) W. J. Flann, M.D.
11/12, 1927 (Address) Rich Jackson Bldg.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL _____	DATE OF BURIAL _____
20. UNDERTAKER _____	ADDRESS _____

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE OR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

AGE SHOULD BE STATED EXACTLY. PHYSICIANS SHOULD STATE EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT.

S-26710