

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

Do not use this space.

26800

**1. PLACE OF DEATH**

County Jackson

Registration District No. 809

File No. \_\_\_\_\_

Township Kau

Primary Registration District No. \_\_\_\_\_

Registered No. 3405

City K.C. Mo

(No. 5011 E 8th 1001)

St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Donna Ann Gust

(a) Residence. No. 5011 E 8th St. 10 Ward.

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

**3. SEX**

Female

**4. COLOR OR RACE**

W.

**5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)**

Married

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

Samuel K. Gust

**6. DATE OF BIRTH (MONTH, DAY AND YEAR)**

Oct 17 - 1884

**7. AGE**

YEARS

MONTHS

DAYS

IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

45

9

28

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work.

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer

**9. BIRTHPLACE (CITY OR TOWN)**

Round

(STATE OR COUNTRY)

Illinois

**10. NAME OF FATHER**

F. A. Curry

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

(STATE OR COUNTRY)

Illinois

**12. MAIDEN NAME OF MOTHER**

Anna Peters

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

(STATE OR COUNTRY)

Illinois

**14. INFORMANT**

Samuel Gust

(Address)

5011 E 8th

**15. FILED**

8/17/30

M. M. Crowe  
asst REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH (MONTH, DAY AND YEAR)**

Aug 15 1930

**17.**

I HEREBY CERTIFY, That I attended deceased from Aug 12, 1930 to Aug 15, 1930 that I last saw h. v. alive on Aug 15, 1930 and that death occurred, on the date stated above, at 11:30 a.m.

**18. THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

137 - Heart Disease  
95 - Tacacarden  
1538

(duration) 3 yrs. mos. ds.

**CONTRIBUTORY (SECONDARY)**

Hemorrhagic menopause

(duration) 3 yrs. mos. ds.

**18. WHERE WAS DISEASE CONTRACTED**

AT PLACE OF DEATH.

**DID AN OPERATION PRECEDE DEATH?**

WAS THERE AN AUTOPSY?

**WHAT TEST CONFIRMED DIAGNOSIS?**

(Signed) R. D. [Signature] M. D.  
8/15/30 (Address) 3201 East 17th

\*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.

**19. PLACE OF BURIAL, CREMATION, OR REMOVAL**

Elmwood

**DATE OF BURIAL**

8/18 1930

**20. UNDERTAKER**

Rose & Henderson 130 Jackson

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.

Dr. Bappon  
120 Benton  
3928  
M