

REC'D FEB 20 1939

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

1241

Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399
 (b) Township Law Primary Registration District No. 1007 Registered No. 254
 (c) City Kansas City (d) Street No. 3937 Park St. _____
 (e) Length of residence in city or town where death occurred 47 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.
 2. PRINT FULL NAME Mrs. Lillie May Owens Gall
 (a) Residence, No. 3937 Park St. (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married
 6A. IF MARRIED, WIDOWED, OR DIVORCED or HUSBAND OF (OR) WIFE OF William Gall
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct. 4, 1884
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
54 3 15
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____
 9. Industry or business in which work was done, as saw mill, bank, etc. at home
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Lebanon Missouri
 FATHER 13. NAME Elisha H. Owens
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Lebanon Missouri
 MOTHER 15. MAIDEN NAME Julia McAlley
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri
 17. INFORMANT (ADDRESS) William Gall
3937 Park
 18. BURIAL, CREMATION, OR REMOVAL PLACE St. Mark's DATE Jan. 28, 1939
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) Dr. Newcomer Sams
Brushcreek + Base
 20. FILED Jan 21, 1939 M. M. Brown
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan. 19, 1939
 22. I HEREBY CERTIFY That I attended deceased from 1/8, 1939, to 1/19, 1939
 I last saw her alive on 1/19, 1939. Death is said to have occurred on the date stated above, at 9:15 P.M.
 The principal cause of death and related causes of importance were as follows:
Uterine Carcinoma Date of onset _____
40
 Other contributory causes of importance: _____
 Name of operation none Date of _____
 What test confirmed diagnosis? V Was there an autopsy? No
 23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place. _____
 Manner of injury _____
 Nature of injury _____
 24. Was disease or injury in any way related to occupation of deceased? No
 If so, specify _____
 (Signed) J. M. Calverton, M. D.
 (Address) 1350 Brooklyn

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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

Registered Apprentice No....., working under my personal supervision.

Signed *C. Hervey Quisenberry*

Licensed Embalmer No. *4070*

P. O. Address *Kansas City,*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

1241
Do not use this space.

1. PLACE OF DEATH
 (a) County Jackson Registration District No. 399
 (b) Township..... Primary Registration District No. 1002 Registered No. 2574
 (c) City Kansas City (d) Street No..... St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.
2. PRINT FULL NAME Lillie May Owens Gall
 (a) Residence, No. St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) M
- 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. |
|--------|-----------|----------|-----------|--|
| | <u>54</u> | <u>3</u> | <u>15</u> | |
- OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.....
9. Industry or business in which work was done, as saw mill, bank, etc.....
10. Date deceased last worked at this occupation (month and year).....
11. Total time (years) spent in this occupation.....
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)
- FATHER
13. NAME
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)
- MOTHER
15. MAIDEN NAME
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)
17. INFORMANT (ADDRESS)
18. BURIAL, CREMATION, OR REMOVAL PLACE..... DATE..... 19.....
19. FUNERAL DIRECTOR (ADDRESS)
20. FILED..... 19..... Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-19, 1937
22. I HEREBY CERTIFY, That I attended deceased from 19... to 19... Death is said to have occurred on the date stated above, at..... m. The principal cause of death and related causes of importance were as follows:
Metastatic Carcinoma Date of onset
- Other contributory causes of importance:
For 11 years
- Name of operation..... Date of.....
 What test confirmed diagnosis?..... Was there an autopsy?.....
23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide?..... Date of injury..... 19.....
 Where did injury occur?..... (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.
- Manner of injury.....
 Nature of injury.....
24. Was disease or injury in any way related to occupation of deceased?.....
 If so, specify J. J. Mc Colman, M. D.
 (Signed)..... (Address) 5829 Broadway N.C. Mo

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

