REC'D JUN 8 1939

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

17802
Do not use this space.

1. PLACE OF DEATH
(a) County Jackson
(b) Township Kaw
(c) City K C Mo
Registration District No. 399
Primary Registration District No. 1002
Registered No. 2204
(d) Street No. K C Gen Hospt 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 200 Reuben Gage
(a) Residence, No. 1415 Bellfontaine 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 M
4. COLOR OR RACE W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) S.
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug-18 1866
7. AGE Years 72 Months 9 Days 8 If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Superintendent
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) Mo

FATHER
13. NAME Jessie Gage
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

MOTHER
15. MAIDEN NAME Elizabeth Shipley
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Md

17. INFORMANT Record Clerk
(ADDRESS) K C Gen Hospt

18. BURIAL, CREMATION, OR REMOVAL
PLACE Marwell Mo. DATE May 28 1939

19. FUNERAL DIRECTOR (NAME) D. W. McDonough
(ADDRESS)

20. FILED May 28 1939 M. M. Crowe
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5-26-39

22. I HEREBY CERTIFY, That I attended deceased from 5-24-39, 19..., to 5-26-39, 19...
I last saw him alive on 5-26-39, 19... Death is said to have occurred on the date stated above, at 9:05 a.m.
The principal cause of death and related causes of importance were as follows:

Coronary occlusion; Myocardial Infarction

Date of onset

Other contributory causes of importance: 94B

Name of operation Date of
What test confirmed diagnosis? Was there an autopsy? Yes

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
(Signed) D. De Maria, M. D.
(Address) General Hospital

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.

X14023

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.....

Licensed Embalmer No.....

P. O. Address.....

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