

DEC 15 1939

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

39954
Do not use this space.

1. PLACE OF DEATH
 (a) County Jasper Registration District No. 411
 (b) Township Joplin Primary Registration District No. 2002 Registered No. _____
 (c) City _____ (d) Street No. 1405 Kentucky 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 William Sherman Gentry
 (a) Residence, No. 1405 Kentucky St. (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) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Anna Lea Trimble

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept 18 - 1866

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>73</u>	<u>1</u>	<u>29</u>	

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

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) Missouri

FATHER 13. NAME Joines Gentry

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Alabama

MOTHER 15. MAIDEN NAME Martha Smith

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown

17. INFORMANT (ADDRESS) Mrs Anna Cardwell
Seymour Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Masonic Ceme DATE Nov 16 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Kelley Ferrell
Seymour Mo

20. FILED 11-15 1939 20 James Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov-15 1939

22. I HEREBY CERTIFY, That I attended deceased from 10-7 1939, to 11-15 1939
 I last saw him alive on 11-15 1939. Death is said to have occurred on the date stated above, at 4:15 P.M.
 The principal cause of death and related causes of importance were as follows:
General Cancer metastatic Date of onset 1-39
7 abdominal viscera

Other contributory causes of importance: _____

Name of operation _____ Date of _____
 What test confirmed diagnosis? Chival Was there an autopsy? _____
XRAY

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 _____
 (Signed) W. Loveland _____, M. D.
Joplin Mo
372 (Address)

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.

1 X14028

RECEIVED

District Health Officer No. 6,

District File Number 1239-2492

Date Filed DEC 7 1939

57

in box

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 K. K. Kelley

Licensed Embalmer No. 3334

P. O. Address Seymour Mo

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.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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1. PLACE OF DEATH

(a) County Jasper Registration District No. 411
 (b) Township Joplin Primary Registration District No. 2002 Registered No. _____
 (c) City _____ (d) Street No. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number) St. _____
 (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 Wm Sherman Gentry

(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

MEDICAL CERTIFICATE OF DEATH

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) wid

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 15, 1939

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

22. I HEREBY CERTIFY, That I attended deceased from _____ to _____, 19____.

I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

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

The principal cause of death and related causes of importance were as follows:

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
73 1 27

Benign Carcinomatosis of abdominal viscera Date of onset _____

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____

unable to determine

9. Industry or business in which work was done, as saw mill, bank, etc. _____

primary test 53

10. Date deceased last worked at this occupation (month and year) _____

11. Total time (years) spent in this occupation _____

Other contributory causes of importance: _____

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.

Name of operation 11/16/39 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 _____

(Signed) H. S. Lovelace, M. D.
 (Address) Joplin

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

SUPPLEMENT

