

6139 MAR 11 1940

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

6139  
Do not use this space.

1. PLACE OF DEATH

(a) County Callaway 3 Registration District No. 104  
(b) Township Fulton Primary Registration District No. 3008  
(c) or City Fulton (d) Street No. State Hosp #1 St.  
(e) Length of residence in city or town where death occurred 17 yrs. 6 mos. 22 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

Registered No. 64

2. PRINT FULL NAME

357 Sherman Gaiden  
(a) Residence, No. Cape Girardeau St.  (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE Negro 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED DK  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF DK  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) DK  
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 65 (approx) DK DK DK  
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. Laborer  
10. Date deceased last worked at this occupation (month and year)  
11. Total time (years) spent in this occupation

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2/27 1940  
22. I HEREBY CERTIFY, That I attended deceased from July 1st 1938 to Feb 27 1940  
I last saw him alive on 2-26 1940 Death is said to have occurred on the date stated above, at 7:10 A.M.  
The principal cause of death and related causes of importance were as follows:  
Pneumonia  
Date of onset 2-24-40  
Other contributory causes of importance:  
107W  
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? No 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. H. Wood J. M. D.  
(Address) State Hosp #1 Fulton Mo

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) DKG  
13. NAME DKG  
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) DKG  
15. MAIDEN NAME DKM  
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) DKI  
17. INFORMANT State Hosp #1 Records (ADDRESS) Fulton Mo  
18. BURIAL, CREMATION, OR REMOVAL PLACE Columbia Mo DATE 2-28 1940  
19. FUNERAL DIRECTOR (NAME) (ADDRESS) J. C. Roberts Columbia Mo  
20. FILED Feb. 28 1940 R. N. Crew Local Registrar

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.

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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.....

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.**