

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

Dr. F. Camp

6697

Do not use this space.

1. PLACE OF DEATH

(a) County GREENE Registration District No. 318
 (b) Township Springfield Primary Registration District No. 5439 Registered No. 138
 or SPRINGFIELD
 (c) City Springfield (d) Street No. Farmers Nursing Home 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

165 Anna Kathryn Gubernator
 (a) Residence, No. 220 E. Chestnut 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 Single		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov. 11 1860				
7. AGE 79	YEARS	MONTHS 2	DAYS 28	If LESS than 1 day, hrs. or min.
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) Buker Hill (STATE OR COUNTRY) Ill.				
FATHER	13. NAME Geo. E. Gubernator			
	14. BIRTHPLACE (CITY OR TOWN) Pennsylvania (STATE OR COUNTRY)			
MOTHER	15. MAIDEN NAME Anna M. Noll			
	16. BIRTHPLACE (CITY OR TOWN) Pennsylvania (STATE OR COUNTRY)			
17. INFORMANT Sister Mary Raymond (ADDRESS) Webster Groves, Mo.				
18. BURIAL, CREMATION, OR REMOVAL PLACE St. Mary DATE Feb. 12 1940				
19. FUNERAL DIRECTOR (NAME) H. H. Lohmeyer (ADDRESS) Springfield, Mo.				
20. FILED <u>2/12/40</u> 19 Chas. A. George M.D. Local Registrar				

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Feb. 9 1940**

22. I HEREBY CERTIFY, That I attended/ deceased from **Feb. 7**, 1940, to **Feb. 9**, 1940
 I last saw her alive on **Feb. 8**, 1940 Death is said to have occurred on the date stated above, at **3 p. m.**
 The principal cause of death and related causes of importance were as follows:

Psychonephritis

Date of onset **1939**

Other contributory causes of importance:

Pneumonia hypostatic
Bronchial

Feb. 7/40

Name of operation **None** Date of **Mo**
 What test confirmed diagnosis? **clinical** 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) **Francis B. Camp**, M. D.
 (Address) **Springfield Mo**

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.

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 *Walter E. Hamilton*

Licensed Embalmer No. *3808*

P. O. Address *Springfield 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.

X