

FILED MAR 4 - 1940

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

7524

Do not use this space.

1. PLACE OF DEATH  
(a) County Madison Registration District No. 605  
(b) Township Conrad Primary Registration District No. 4359  
(c) 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 Robt G Gary  
(a) Residence, No. Parma 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 Male 4. COLOR OR RACE Black 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

6. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Luvia Gary

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 10-27-1895

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
54 2 25

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

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) Miss.

13. NAME Steward Gary

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

15. MAIDEN NAME Bollie Charabales

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

17. INFORMANT (ADDRESS) Luvia Gary

18. BURIAL, CREMATION, OR REMOVAL PLACE Catons DATE 1-28 1940

19. FUNERAL DIRECTOR (NAME) W. H. Bros.

(ADDRESS) W. H. Bros.

20. FILED 1/22 1940 Dr. G. W. G. (Signature)

Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 22, 1940

22. I HEREBY CERTIFY That I attended deceased from Jan 14, 1940, to Jan 22, 1940

I last saw him alive on Jan 14, 1940 Death is said to have occurred on the date stated above, at 1:30 p.m.

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

Pneumonia  
Golbs

Date of onset

Other contributory causes of importance: 105

Name of operation Clonic Date of .....

What test confirmed diagnosis? .....

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? .....

Where did injury occur? .....

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 Clonic

(Signed) Dr. G. W. G. M. D.

(Address) Parma

(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.

Health Officer No. \_\_\_\_\_  
District File Number 240-62  
Date Filed 2/26/40

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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.**