

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 431

Primary Registration District No. 3023

Registrar's No. 84

1. PLACE OF DEATH:
 (a) County Johnson
 (b) City or town Warrensburg
 (c) Name of hospital or institution: _____
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether)
 In this community 34 yrs. (years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Johnson
 (c) City or town Warrensburg
 (If outside city or town limits write "RURAL")
 (d) Street No. _____ (If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME Eva May Gentry
 8. (b) If veteran, name war _____
 3. (c) Social Security No. 87-07-0888

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month July - day 7
 year 1940 hour 40 minute 7 A.M.
 21. I hereby certify that I attended the deceased from about
March 1939 to July 7, 1940
 that I last saw her alive on July 7, 1940
 and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White
 6. (a) Single, widowed, married, divorced Single
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Nov. 11 - 1886
 (Month) (Day) (Year)

Immediate cause of death Septicemia (bacterial)
Streptococcus viridans
 Duration 15-18
MO.

8. AGE: Years 53 Months 7 Days 36
 If less than one day _____ hr. _____ min.

Due to _____
 Due to _____

9. Birthplace Bates Co. Mo.
 (City, town, or county) (State or foreign country)
 10. Usual occupation Secretary

Other conditions (Include pregnancy within 3 months of death)
 Major findings: Of operations no
 Of autopsy no

MOTHER FATHER
 11. Industry or business _____
 12. Name John H. Gentry
 18. Birthplace Unknown Ill.
 (City, town, or county) (State or foreign country)
 14. Maiden name Sarah G. Dean
 15. Birthplace Janesville Ind.
 (City, town, or county) (State or foreign country)

PHYSICIAN
 Underline the cause to which death should be charged statistically.

16. (a) Informant's own signature Beatrice Gentry
 (b) Address Warrensburg Mo.

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) no
 (b) Date of occurrence _____
 (c) Where did injury occur? _____ (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? no

17. (a) Burial (b) Date thereof July 9 - 1940
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Drexel Hall

(Specify type of place)
 White at work _____ (e) Means of injury _____

18. (a) Signature of funeral director Queeney - Pullin
 (b) Address Warrensburg Mo.
 19. (a) July 9 - 1940 (b) Hornig
 (If he received local registrar) (Registrar's signature)

23. Signature W. P. Coopers (M. D. or other) MD
 Address Warrensburg Mo. Date signed 7-9-40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

Rev. 5-17-39 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.

36

Date filed 8-7-40
Official No. 87

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.....

Earl Priest, Registered Apprentice No.....
working under my personal supervision.

Signed *Earl Priest*
Licensed Embalmer No. *3878*
P. O. Address *Warrensburg, 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. **25-5-15**
Registrar's No. **84**

Registration District No. **431**

Primary Registration District No. **3023**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County **Jackson**

(b) City or town **Warrensburg**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution..... (Specify whether
In this community..... (Specify whether
years, months or days)

3. (a) PRINT FULL NAME **Eva May Gentry**

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex **F** 5. Color or race **W** 6. (a) Single, widowed, married, divorced.....

6. (b) Name of husband or wife..... 6. (c) Age of husband, or wife, if alive..... year.....

7. Birth date of deceased..... (Month) (Day) (Year)

8. AGE: Years **53** Months **7** Days **26** If less than one day..... min.

9. Birthplace..... (City, town, or county) (State or foreign country)

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER { 12. Name.....

13. Birthplace..... (City, town, or county) (State or foreign country)

14. Maiden name.....

15. Birthplace..... (City, town, or county) (State or foreign country)

16. (a) Informant..... (b) Address.....

17. (a)..... (b) Date thereof..... (Month) (Day) (Year)
(Burial, cremation, or removal) (Place: burial or cremation.....)

18. (a) Signature of funeral director..... (b) Address.....

19. (a)..... (b)..... (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....

(c) City or town..... (If outside city or town limits write "RURAL")

(d) Street No..... (If rural, give location)

(e) If foreign born, how long in U. S. A.?..... years.

MEDICAL CERTIFICATION

20. DATE OF DEATH..... month **July** day **7**
year **1940** hour..... minute..... M.

21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....; that I last saw him..... alive on....., 19.....; and that death occurred on the date and hour stated above.

Immediate cause of death **Septicemia (Bacterial)**
Streptococcus Viridans
Due to **Acute tonsillar infection**
(Acute exacerbation of Chronic tonsillar infection) **16 Mo.**

Other conditions..... (Include pregnancy within 3 months of death)

Major findings: **115 u**

Of operations.....

Of autopsy.....

PHYSICIAN
→
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify).....

(b) Date of occurrence.....

(c) Where did injury occur?..... (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?.....

While at work?..... (Specify type of place) (e) Means of injury.....

23. Signature **E. P. Cooper** (M. D. or other)
Address **Warrensburg Mo.** Date signed **7-40**

SUPPLEMENTARY

