

Registration District No. **464**

Primary Registration District No. **4277**

Registrar's No. **44**

FEB DEC 11 1940

**1. PLACE OF DEATH:**

(a) County **Lafayette**  
(b) City or town **Odessa**  
(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) **2**  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community **40 Yrs.** years, months or days

**2. USUAL RESIDENCE OF DECEASED:**

(a) State **Missouri** (b) County **Lafayette**  
(c) City or town **Odessa**  
(If outside city or town limits, write "RURAL") **0**  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME **Alene Gent**

3. (b) If veteran, name war \_\_\_\_\_ 8. (c) Social Security No. \_\_\_\_\_

4. Sex **Fe** 5. Color or race **Negro** 6. (a) Single, widowed, married, divorced **Widow**

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased **Jan. 29, 1899**  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
**41 9 20** hr. min.

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

10. Usual occupation **Housekeeper** **0**

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name **Mark Washington**

13. Birthplace **Lafayette Co., Mo.** **0**  
(City, town, or county) (State or foreign country)

14. Maiden name **Edna Sims** **0**

15. Birthplace **Mo.** **0**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Gene Washington**

(b) Address **Odessa, Mo.**

17. (a) **Burial** (b) Date thereof **Nov. 21, 1940**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Odessa, Mo.**

18. (a) Signature of funeral director **H. H. Human**

(b) Address **Odessa, Mo.**

19. (a) **Nov. 20, 1940** (Date received local registrar)

**Wm E. M. Gordon** (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Month **Nov** day **19**  
year **1940** hour **Two** minute **30 P.M.**

21. I hereby certify that I attended the deceased from **Nov 16** 19**40** to **Nov 19** 19**40**  
that I last saw her alive on **Nov 18** 19**40** and that death occurred on the date and hour stated above.

Immediate cause of death **Heart failure and Pulmonary Congestion**

Due to **Acute Heart Failure**

Due to **Nephritis**

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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? \_\_\_\_\_

**416** (Specify type of place) While at work (e) Means of injury \_\_\_\_\_

23. Signature **A. Schaefer** (M. D. or other) \_\_\_\_\_

Address **Odessa, Mo.** Date signed **11/21/40**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

74  
8  
0

132

RECEIVED  
District Health Officer No. 8,  
District File Number  
Date Filed 12-7-40

**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 Joseph L. Husman

Licensed Embalmer No. 7541

P. O. Address Adena 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

State File No. **39036**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. **464**

Primary Registration District No. **4277**

Registrar's No. **44**

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

1. PLACE OF DEATH

(a) County **Lafayette**  
(b) City or town **Adessa**  
(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 \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME **Alene Gant**

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

4. Sex **7** 5. Color **Black** 6. (a) Single, widowed, married, divorced **wid**  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ years

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

8. AGE: Years **41** Months **9** Days **20**  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_  
(City, town, or county) (State or foreign country)

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

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

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) 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.

20. DATE OF DEATH Month **Nov** day **19**  
year \_\_\_\_\_ 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 **Asthma and Pulmonary Congestion**  
Due to **ascites**

Due to **nephritis (Chronic)**  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: **171**  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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 **R. Scheraga** (M. D. or other)  
Address **Adessa Mo** Date signed **12/9/41**

SUPPLEMENTAL REPORT

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

S-39036 - 1940