

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

10832

State File No. _____

Registration District No. 384

Primary Registration District No. 4227

Registrar's No. _____

1. PLACE OF DEATH:

(a) County HOWELL
 (b) City or town WEST PLAINS
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: MONKS ST. 1
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution No.
 (Specify whether
 In this community LIFETIME
 years, months or days)

8. (a) PRINT FULL NAME DELLA JULIA GABBERT
 8. (b) If veteran, name war _____
 8. (c) Social Security No. _____

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced, MARRIED
 6. (b) Name of husband or wife Dr. A. J. GABBERT 6. (c) Age of husband or wife if alive 78 years
 7. Birth date of deceased MARCH 15, 1891
 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
<u>50</u>	<u>0</u>	<u>9</u>	hr. _____ min.

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

10. Usual occupation NONE

11. Industry or business _____

MOTHER FATHER
 { 12. Name JAMES COLE
 18. Birthplace _____ VA. 1
 (City, town, or county) (State or foreign country)
 { 14. Maiden name Lydia Ellen Gillett
 15. Birthplace Maysville Ky 1
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Dr. A. J. Gabbert
 (b) Address WEST PLAINS, Mo.

17. (a) BURIAL (b) Date thereof MAR. 25, 1941
 (Burial, cremation, or removal) OAK LAWN CEM. (Month) (Day) (Year)
 (c) Place: burial or cremation WEST PLAINS, MO.

18. (a) Signature of funeral director Hal Thomburg
 (b) Address WEST PLAINS, MO.

19. (a) 3-24-41 (b) Vida W SIMONS
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County HOWELL
 (c) City or town WEST PLAINS
 (If outside city or town limits, write "RURAL")
 (d) Street No. MONKS ST.
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. 0 years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MARCH day 24
 year 1941 hour 1: minute 10 a. M.

21. I hereby certify that I attended the deceased from Jan 6, 1941 to March 24, 1941
 that I last saw her alive on March 23, 1941
 and that death occurred on the date and hour stated above.

Immediate cause of death Cancer of Cervix
 Due to _____
 Due to _____
 Other conditions Cancer of Uterus
 (Include pregnancy within 3 months of death) Secondary

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

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? 3411
 (Specify type of place) (e) Means of injury _____
 While at work? _____
 23. Signature E. Claude John (M. D. or other) MD
 Address West Plains, Mo Date signed 3-25-41

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.

RECEIVED

District Health Officer No. 5,

District File Number. 441477

Date Filed

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.....

Hal Thomburg

Licensed Embalmer No. 3400

P. O. Address

West Plains,

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.