

No. 2
4-13-40
5-17-39
I X23159

MAY 9 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 16209

Registration District No. 907

Primary Registration District No. 6220

Registrar's No. 5

1. PLACE OF DEATH:

(a) County Wright

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

(c) Name of hospital or institution Pleasant Hill
(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 Sarah Elizabeth Gaskin

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex M

5. Color or race W.

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband Thomas R. Gaskin

6. (c) Age of husband or wife if alive 82 years

7. Birth date of deceased Dec 1 1863
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>77</u>	<u>3</u>	<u>14</u>	hr. _____ min. _____

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

10. Usual occupation Housekeeper

11. Industry or business _____

MOTHER FATHER

12. Name George Reese

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

14. Maiden name Aggie Todd

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

16. (a) Informant Mrs Vera Gaskill

(b) Address Mansfield Mo

17. (a) Burial (Burial, cremation, or removal)

(b) Date thereof Mar 15 1941 (Month) (Day) (Year)

(c) Place: burial or cremation Seymour home

18. (a) Signature of funeral director Kelley Ferrell

(b) Address Seymour Mo

19. (a) April 16 1941 (Date received local registrar)

(b) J.M.D. Short (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Wright

(c) City or town Cedar Gap (If outside city or town limits, write "RURAL")

(d) Street No. 6 mi. W. (If rural, give location)

(e) If foreign born, how long in U. S. A.? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 13 year 1941 hour 3 minute 30 P.M.

21. I hereby certify that I attended the deceased on _____, 19____, to 2-28-41, 19____; that I last saw her ER alive on 2-28-41, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia cellulitis of lower right extremity

Due to Senile arteriosclerosis

Due to _____

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? 832 (Specify type of place) _____

While at work? _____ (e) Means of injury _____

23. Signature Howard J. Mason (M. D. or other) DO

Address Fordland Mo. Date signed 3-15-41

Duration 3 wks.

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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

114
0
0

97
RECEIVED

District Health Officer No. 6;

District File Number 541-744

Date Filled MAY 7 1941

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 K H Kelley

Licensed Embalmer No. 333411

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, fact should be so stated above.

Registration District No. 909

Primary Registration District No. 6220

1. PLACE OF DEATH:

(a) County Wright
(b) City or town Pleasant Valley
(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 Sarah Elizabeth Gasper

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 m

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 77 Months 3 Days 14 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 _____

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

16. (a) In _____

(b) _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 13
year 1941 hour _____ minute _____ M.

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

Immediate cause of death Phlegmonous Duration _____

Cellulitis of lower st

Due to Extremity due to _____

Due to Arteriosclerosis

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

Major findings:
Of operations _____
Of autopsy 97

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 Harold J Moore (M. D. or other) do

Address Jordanland Date signed 6-27-41

SUPPLEMENTAL

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

MOTHER FATHER



