

Registration District No. 875

Primary Registration District No. 6162

Registrar's No. 26

1. PLACE OF DEATH:

(a) County Jerusalem
 (b) City or town Madison Township
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
State Hosp #3 Nevada, Mo
(If not in hospital or institution, write street number of location)
 (d) Length of stay: In hospital or institution one 15hr
(Specify whether)
 In this community years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Barton
 (c) City or town Jerman
(If outside city or town limits, write "RURAL")
 (d) Street No. 800 Maple St
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Bessie Lemaster Gentry
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female Color or race W
 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Andrew P. Lewis Gentry (c) Age of husband or wife if alive unknown
 7. Birth date of deceased June 2 1881
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>60</u>	<u>10</u>	<u>14</u>	hr. _____ min. _____

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

10. Usual occupation Homemaker

11. Industry or business _____

12. Name Samuel Lemaster

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

14. Maiden name unknown

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

16. (a) Informant State Hosp #3 Records

(b) Address Merally mo

17. (a) Removal (b) Date thereof 4/11/42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lake Segawing

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

19. (a) 4-17-42 (b) Gentry & Steiner
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 17
 year 1942 hour 2 minute 30 A.M.
 21. I hereby certify that I attended the deceased from year 2
 1942 to April 17 1942

that I last saw her alive on April 16 1942 and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia, St. I
 Duration _____

Due to _____

Due to _____

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

Major findings: 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 R. N. Gentry (M. D. or other) MD

Address State Hosp #3 Nevada, Mo Date signed 4/17/42

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

MOTHER FATHER

RECEIVED

District Health Officer No. 7,

District File Number 5-42-503

Date Filed 5-13-42

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 + [Signature]

Licensed Embalmer No. 13141

P. O. Address Lamar Pa

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

2B
21-41
29288

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 15 826

Registration District No. 875

Primary Registration District No. 6162

Registrar's No. _____

1. PLACE OF DEATH: Verona
 (a) County Verona
 (b) City or town Verona
 (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 Bessie L. 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 M

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

7. Birth date of deceased June 2 1884
 (Month) (Day) (Year)

8. AGE: Years 60 Months 10 Days 15 If less than one day _____ min.

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

10. Usual occupation _____

11. Industry of 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)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan Day _____ Year 1942 hour _____ minute _____ M.

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

Immediate cause of death Brodyspneumonia
pneumonia Duration _____

Due to _____

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? _____

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

23. Signature _____ (M. D. or other) _____
 Address _____ Date signed _____

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

SUPPLEMENTARY

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

