

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

15685
Do not use this space.

FILED MAY 15 1943

1. PLACE OF DEATH

(a) County Stone Registration District No. 344
(b) Township James TP. Primary Registration District No. 6/263
(c) City Reds (d) Street No. _____ (If death occurred in Hospital or Institution, write its name instead of street and number) St. _____
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Barbe Sue Gilbert

(a) Residence, No. _____ St. (If nonresident, give city or town and State) _____
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Fem. 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
5 16

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) Stone Co. Mo. (STATE OR COUNTRY)

FATHER
13. NAME Lester Gilbert

14. BIRTHPLACE (CITY OR TOWN) Carmell Co. Ark. (STATE OR COUNTRY)

MOTHER
15. MAIDEN NAME Meta Barton

16. BIRTHPLACE (CITY OR TOWN) Ark. (STATE OR COUNTRY)

17. INFORMANT Lester Gilbert (ADDRESS) Radical, MO

18. BURIAL, CREMATION, OR REMOVAL PLACE Blue Eye DATE 3-27-43

19. FUNERAL DIRECTOR (NAME) none (ADDRESS)

20. FILED 4-9 1943 Chester D. Seave Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3-26-43, 1943

22. I HEREBY CERTIFY, That I attended deceased from 3-26-, 1943, to 3-26-43, 1943.
I last saw her alive on 3-26-43, 1943. Death is said to have occurred on the date stated above, at 9 p. m.
The principal cause of death and related causes of importance were as follows:

Pneumonia (Bronchio)

Other contributory causes of importance:

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 1943.
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased?
If so, specify _____
(Signed) W. E. Cottrell, M. D.
(Address) Reds Spring, Mo.

RECEIVED

District Health Officer No. 6,

District File Number 543-582

Date Filed MAY 13 1943

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.....

Licensed Embalmer No.....

P. O. Address.....

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. 15-683

Registration District No. 344

Primary Registration District No. 6186

Registrar's No. 6

1. PLACE OF DEATH:

(a) County Stone
(b) City or town Rural
(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 Barbara Sue Gilbert

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 S

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 Months Days If less than one day min.

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

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) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (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 March Day 6 Year 1943 Hour minute M.

21. I hereby certify that I attended the deceased from 9 19... that I last saw him alive on 19... and that death occurred on the date and hour stated above. Immediate cause of death pneumonia

Other conditions: bronchitis

Due to: No complications

Due to: none

Other conditions: none

Major findings: Of operations

Of autopsy: 107

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) (2) Means of injury

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

SUPPLEMENTARY

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

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

S-15685