

FILED DEC. 8 1943

Registration District No. \_\_\_\_\_

Primary Registration District No. 5386

Registrar's No. 160

1. PLACE OF DEATH:

(a) County Dent

(b) City or town Norman  
(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 X  
In this community about two years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dent

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

(d) Street No. \_\_\_\_\_  
(If rural, give location)

(e) Citizen of foreign country? X (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME William Thomas Gamblin

3. (b) If veteran, name war X

3. (c) Social Security No. X

4. Sex male

5. Color or race W

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

6. (b) Name of husband or wife Martha Jane

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

7. Birth date of deceased Dec 19 1863  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

79 10 26 \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation farmer

11. Industry or business X

MOTHER FATHER

12. Name William Gamblin

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 William Gamblin

(b) Address \_\_\_\_\_

17. (a) burial (b) Date thereof 11/17/43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Union Cem

18. (a) Signature of funeral director \_\_\_\_\_  
(b) Address Salem Mo

19. (a) 11-19-43 (b) Joe D. McLeod  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 15  
year 1943 hour 9 minute 30 A. M.

21. I hereby certify that I attended the deceased from Sept 19 1943 to Nov 4 1943  
that I last saw him alive on Nov 4 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Apoplexy  
Chronic Nephritis

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

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

Of autopsy no

Duration 3 months

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 Joe D. McLeod (M. D. or other) \_\_\_\_\_  
Address Salem Mo Date signed 11-16-43

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

RECEIVED

District Health Officer No. 5,

District File Number. 1243688

Date Filed 12-21-42

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D  
E

**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 Carl H. Spencer

Licensed Embalmer No. 9370

P. O. Address Salisbury Md

**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.