S. No. 2
M—8-43
. 5-17-39
I X37823

97
3
0

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED DEC 13 1944

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 38919

Registration District No. 923 Primary Registration District No. 4474 Registrar's No. 29

1. PLACE OF DEATH:

(a) County SALINE
(b) City or town SWEET SPRINGS (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 30 years (years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Saline 97
(c) City or town Sweet Springs Mo. (If outside city or town limits, write "RURAL")
(d) Street No. N. Miller St. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME John HUNTER GASH.
3. (b) If veteran, name war ✓
3. (c) Social Security No. ✓
4. Sex MALE
5. Color or race White
6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife Mollie Alice Gash
6. (c) Age of husband or wife if alive 73 years
7. Birth date of deceased DEC (Month) 1 (Day) 1870 (Year)

8. AGE: Years 72 Months 11 Days 29 If less than one day hr. min.

9. Birthplace LINN Co (City, town, or county) Mo (State or foreign country)
10. Usual occupation FARMER
11. Industry or business TILLER of Soil
FATHER
12. Name Wm GASH
13. Birthplace (City, town, or county) Mo (State or foreign country)
MOTHER
14. Maiden name STACIE McCOLLINS
15. Birthplace (City, town, or county) Mo (State or foreign country)
16. (a) Informant Mrs Mollie Gash
(b) Address Sweet Springs Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/3/44 (Month) (Day) (Year)
(c) Place: burial or cremation Fairmount Cemetery
18. (a) Signature of funeral director R C Carter
(b) Address Sweet Springs Mo
19. (a) Dec 3-44 (Date received local registrar) (b) Mrs Dora Hoffman (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 30 year 1944 hour 12 minute 30 a M.
21. I hereby certify that I attended the deceased from Investigated Nov 30, 1944, 19; that I last saw him alive on, 19; and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage
Due to
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations
Of autopsy No

Duration

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? (Specify type of place)
While at work? (e) Means of injury
23. Signature C. L. Lawless Coroner Saline Co. (M. D. or other)
Address Marshall Mo Date signed 11-30-44

1218

(Licensed Embalmer's Statement on Reverse Side)

[illegible]
[illegible] Officer No. 8.
Disease File No. [illegible]
Date [illegible] 12-11-44

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 R C Carter

Licensed Embalmer No. 3513

P. O. Address [illegible]

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.