No. 2
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17-39
X23159

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

41331

State File No.

FILED JAN 14 1946

Registration District No. 139

Primary Registration District No. 5 5 3 2 4 2 2 3

Registrar's No. 36

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

1. PLACE OF DEATH:

(a) County Holt

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

(c) Name of hospital or institution: No 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution No (Specify whether years, months or days)

In this community all his life

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Holt 44

(c) City or town Maitland Mo 0
(If outside city or town limits, write "RURAL")

(d) Street No. — 'Rural' 0
(If rural, give location)

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

3. (a) PRINT FULL NAME Rachel Melba Gaddy

3. (b) If veteran, name war —

3. (c) Social Security No. —

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife Roy V Gaddy

6. (c) Age of husband or wife if alive 34 years

7. Birth date of deceased August (Month) 24 (Day) 1911 (Year)

8. AGE: Years 34 Months 4 Days 4 If less than one day ..... hr. ..... min.

9. Birthplace Maitland (City, town, or county) Mo. 0 (State or foreign country)

10. Usual occupation House wife

11. Industry or business —

FATHER
12. Name William Rowlett
13. Birthplace Unknown (City, town, or county) England 4 (State or foreign country)

MOTHER
14. Maiden name Augusta Burgner
15. Birthplace Bigelow (City, town, or county) Mo. 0 (State or foreign country)

16. (a) Informant Roy V Gaddy
(b) Address Maitland Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-31-45 (Month) (Day) (Year)
(c) Place: burial or cremation K of P Maitland

18. (a) Signature of funeral director Campbell Funeral Home
(b) Address Maryville Mo

19. (a) 12-31-45 (Date received local registrar) (b) J Chaney (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 28 year 1945 hour ..... minute ..... M.

21. I hereby certify that I attended the deceased from May 5, 1945 to Dec 28, 1945 that I last saw her alive on Dec 27, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Sarcoma

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations Sarcoma

Of autopsy

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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 D B Perry (M. D. or other) MD

Address Mound City Mo Date signed 12-31-45

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 11,
District File Number _____
Date Filed _____

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 ~~Marjorie L.~~, Registered Apprentice No. _____ working under my personal supervision.

Signed Marjorie L. Campbell

Licensed Embalmer No. 4392

P. O. Address Marysville, Ma

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

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

S. No. 2B
5M—3-45
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Jan

Registration District No. 139 Primary Registration District No. 4223 Registrar's No. 36

1. PLACE OF DEATH:
(a) County Hall
(b) City or town Maitland
(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 years, months or days)
In this community

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

3. (a) PRINT FULL NAME Rachel M. Gaddy
3. (b) If veteran, name war
3. (c) Social Security No. 0
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 Aug 24 1896 (Month) (Day) (Year)
8. AGE: Years 34 Months 4 Days 4 If less than one day hr. min.
9. Birthplace (City, town, or county) Mo (State or foreign country)
10. Usual occupation
11. Industry or 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) (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)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec Day 28 year 1944 hour minute M.
21. I hereby certify that I attended the deceased from , 19 to , 19 ; that I last saw him alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Anterior	
Due to Abdominal	
Due to Weak	
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? (Specify type of place)
While at work? (e) Means of injury
23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

41331