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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 9 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 16378

Registration District No. 10

Primary Registration District No. 3002

Registrar's No. 92

1. PLACE OF DEATH:

(a) County Audrain

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

(c) Name of hospital or institution:
532 W. Jackson 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 30 yrs.
(Specify whether years, months or days)

In this community 30 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Audrain

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

(d) Street No. 532 W. Jackson 1
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME GILES GASKINS

3. (b) If veteran, name war ✓

3. (c) Social Security No. 560-09-9040

4. Sex Male

5. Color or race Negro

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

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

7. Birth date of deceased: Unknown
(Month) (Day) (Year)

8. AGE: Years about 75 Months 1 Days 4 If less than one day hr. _____ min. 9

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

10. Usual occupation laborer

11. Industry or business _____

MOTHER FATHER

12. Name Unknown

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 country)

16. (a) Informant Jaimita Jacobs

(b) Address 532 W. Jackson

17. (a) Burial (b) Date thereof: 6-10-1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mexico Mo

18. (a) Signature of funeral director W. J. Letow

(b) Address 161 W. Western Mexico Mo

19. (a) May 31-1947 (b) Blanche Neely
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 29
year 1947 hour 7 minute 15 P. M.

21. I hereby certify that I attended the deceased from 5-10-1947 to 5-29-1947
that I last saw him alive on 5-29-1947 and that death occurred on the date and hour stated above.

Immediate cause of death: Chronic Myocarditis
Arteriosclerosis

Due to _____

Due to _____

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

Major findings: _____
Of operations: _____

Of autopsy: _____

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? _____

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

23. Signature W. J. Letow (M. D. or other) _____

Address Mexico Mo Date signed 5-30-47

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

JUN 11 1947

RECEIVED
District Health Officer No. 10
District File Number 6-47-654
Date Filed JUN - 5 1947

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 J P Alexander

Licensed Embalmer No. 4245

P. O. Address Dedham

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.