

No. 2
-8-43
-17-39
X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 13 1948

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **44693**
Registrar's No. _____

Registration District No. 78

Primary Registration District No. 4293

1. PLACE OF DEATH:
(a) County LINCOLN
(b) City or town ELSBERRY
(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 _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State MO (b) County Lincoln
(c) City or town Elsberry (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 Gabriel Walter Damron
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month OCT. day 8
year 1947 hour 12 minute 00 (M)

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Sept 14 1962
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from OCT 7, 1947, to OCT 8, 1947;
that I last saw him alive on OCT 8, 1947;
and that death occurred on the date and hour stated above.
Immediate cause of death _____
CONGESTIVE HEART FAILURE Duration 2 days

8. AGE: Years 85 Months _____ Days 24 If less than one day _____ hr. _____ min.

Due to CORONARY OCCLUSION 3 days
Due to ARTERIAL HYPERTENSION 1 year
GEN. ARTERIO SCLEROSIS 1 year
Other conditions _____ (Include pregnancy within 3 months of death)
Major findings: _____
Of operations 0
Of autopsy NOT DONE

9. Birthplace Damron Mo (City, town, or county) (State or foreign country)
10. Usual occupation Retired farmer

11. Industry or business _____
12. Name John Damron
13. Birthplace Virginia (City, town, or county) (State or foreign country)
14. Maiden name unknown
15. Birthplace unknown (City, town, or county) (State or foreign country)

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant John Damron
(b) Address St. Louis, Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/10/47 (Month) (Day) (Year)
(c) Place: burial or cremation Rose Hill Cem.
18. (a) Signature of funeral director Clifton Miller
(b) Address Elsberry Mo
19. (a) 10/11/47 (Date received local registrar) (b) Mrs. T. A. Dwyer (Registrar's signature) 11/14

22. If death was due to external causes, fill in the following:
(c) 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) (c). Means of injury _____
23. Signature E. Damron (M. D. or other) M.D.
Address ELSBERRY, MO Date signed 10/10/47

(Licensed Embalmer's Statement on Reverse Side)

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

MOTHER FATHER

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed *2/11/48*

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 *Oct 2 1947*

....., Registered Apprentice No.
working under my personal supervision.

Signed *Clifton Mills*
Licensed Embalmer No. *3364*
P. O. Address *Elberon, 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.