

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **27439**

FILED AUG 21 1952

BIRTH NO. _____ REG. DIST. NO. **58** PRIMARY REG. DIST. NO. **4088** Registrar's No. **38**

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD — 0180

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|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Carter | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Mo b. COUNTY Carter | |
| b. CITY (If outside corporate limits, write RURAL and give township) Ellsinore | c. LENGTH OF STAY (in this place) 3 years | c. CITY (If outside corporate limits, write RURAL and give township) Ellsinore | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION own home | | d. STREET ADDRESS (If rural, give location) 0 | |

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|---|---|
| 3. NAME OF DECEASED (Type or Print) a. (First) Sona b. (Middle) Elizabeth c. (Last) Gaines | 4. DATE OF DEATH (Month) (Day) (Year) Aug 8 1952 |
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|--------------------|----------------------------------|---|--|--|---|---|
| 5. SEX F | 6. COLOR OR RACE White | 7. MARRIED (NEVER MARRIED, WIDOWED, DIVORCED) (Specify) married | 8. DATE OF BIRTH Sept 3 1879 | 9. AGE (In years last birthday) 72 | 10. UNDER 1 YEAR Months _____ Days _____ | 11. UNDER 14 HRS. Hours _____ Min. _____ |
|--------------------|----------------------------------|---|--|--|---|---|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | 10b. KIND OF BUSINESS OR INDUSTRY own home | 11. BIRTHPLACE (State or foreign country) Ill | 12. CITIZENRY OF WHAT COUNTRY? U.S.A. |
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|---|---|---|
| 13a. FATHER'S NAME B. J. Shephard | 13b. MOTHER'S MARRIAGE NAME Isabella Boyd | 14. NAME OF HUSBAND OR WIFE William H. Gaines |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no | 16. SOCIAL SECURITY NO. _____ | 17. INFORMANT'S SIGNATURE OR NAME William H. Gaines | ADDRESS Ellsinore |
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| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH |
| | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma, Ear (external) | | |
| | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Metastasis to Lungs DUE TO (c) _____ | | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | |

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|------------------------|----------------------------------|---|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
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| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 197X |
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| | | |
|---|--|----------------------------|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? |
|---|--|----------------------------|

22. I hereby certify that I attended the deceased from **6-4**, 19**47**, to **Aug 8**, 19**52**, that I last saw the deceased alive on **Aug 8**, 19**52**, and that death occurred at **9:40 A.M.**, from the causes and on the date stated above.

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| 23a. SIGNATURE Frank E. Ince | (Degree or title) Dr. (Assistant) Ph.D., M.D. | 23b. ADDRESS Ellsinore, Mo | 23c. DATE SIGNED 8-16-52 |
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|--|------------------------------|--|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24b. DATE Aug 8-52 | 24c. NAME OF CEMETERY OR CREMATORY Scott | 24d. LOCATION (City, town, or county) (State) Carter Co Mo |
|--|------------------------------|--|--|

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|--|--|------|--|-----------------------------|
| DATE REC'D BY LOCAL REG. Aug 20-52 | REGISTRAR'S SIGNATURE Mrs. Octa Nelson | 50-0 | 25. FUNERAL DIRECTOR'S SIGNATURE Seaton Jewett | ADDRESS Van Buren |
|--|--|------|--|-----------------------------|

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.....

..... Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed Seaton Hewitt

Licensed Embalmer No. 2287

P. O. Address Van Buren Mo

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.