

Health, Welfare, Public, Service

FILED SEP 3 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

27928

STATE FILE NUMBER

Registration District No. 10-5-1044 Primary Registration District No. 4177 Registrar's No. 6

1. PLACE OF DEATH a. COUNTY <b>Dunklin</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Dunklin</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Clarkton</b>		c. CITY OR TOWN <b>Clarkton</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>City</b>		d. STREET ADDRESS <b>City</b>	
Length of stay in lb <b>3 yrs.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>SAMUEL</b> Middle <b>C.</b> Last <b>GALES</b>			4. DATE OF DEATH Month <b>July</b> Day <b>31</b> Year <b>1957</b>		
---	--	--	--	--	--

5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 25, 1874</b>	9. AGE (In years last birthday) <b>83</b>	IF UNDER 1 YEAR Months <b>02</b> Days <b>25</b>	IF UNDER 24 HRS. Hours <b>02</b> Min. <b>25</b>
--------------------	-------------------------------	--	---------------------------------------	---	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Dresden, Tennessee</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
--	-----------------------------------	---	---

13a. FATHER'S NAME <b>Sam Gales</b>	13b. MOTHER'S MAIDEN NAME <b>Nancy Thomas</b>	14. NAME OF HUSBAND OR WIFE <b>Betty Gales</b>
--	--	---

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>Unknown</b>	17. INFORMANT Address <b>Mrs. Betty Gales, Clarkton, Missouri</b>
--	---	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b>		INTERVAL BETWEEN ONSET AND DEATH <b>15 min.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
---	--	---

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
---	--

20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY _____ STATE _____
---	--	--	--

21. I attended the deceased from _____, to _____ and last saw her/him alive on _____ Death occurred at _____ <b>2</b> a.m. on the date stated above; and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE (Degree or title) <b>Quinton Tarver, M.D., Coroner</b>	22b. ADDRESS <b>Kennett, Missouri</b>	22c. DATE SIGNED <b>8-2-57</b>
--	--	-----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>August 1, 1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Stanfield Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Clarkton, Mo. Rte. 1</b>
--	------------------------------------	---	--

24. FUNERAL DIRECTOR <b>Landess Funeral Home, Campbell, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>8-13-57</b>	26. REGISTRAR'S SIGNATURE <b>J. D. Schuman</b>
--	--	---

(Licenses Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION  
All diseases in Part I must be causally related.

7

RECEIVED DUNKLIN COUNTY HE

DEPARTMENT ..... 8-27-

COUNTY FILE NUMBER 857-

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 .....  
Signature of Student Embalmer

Signed *Christina M. Landes* .....

Licensed Embalmer No. 4227 .....

P. O. Address *Campbell,* .....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.