REC'D AUG 4 1939

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

25384
Do not use this space.

1. PLACE OF DEATH
(a) County Clay — Registration District No. 198
(b) Township Fishing River — Primary Registration District No. 2011 — Registered No. 95
(c) City Excelsior Springs (d) Street No. Excelsior Hospital St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred 5 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Fern Estiline Gaines
(a) Residence, No. 105 Port Look St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS	MEDICAL CERTIFICATE OF DEATH
3. SEX: Female — 4. COLOR OR RACE: White — 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Married	21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 2, 1939
5a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Walter C. Gaines	22. I HEREBY CERTIFY, That I attended deceased from June 18, 1939, to July 2, 1939. I last saw her alive on July 2, 1939. Death is said to have occurred on the date stated above, at 10.75 a.m.
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 29-1914	The principal cause of death and related causes of importance were as follows: Obstetrical Delivery — Date of onset June 18-39; Chill & Peritanitis June 20-39; (Acute Peritonitis)
7. AGE: Years 24 — Months 11 — Days 3 — If LESS than 1 day, ...hrs. or ...min.	Other contributory causes of importance: Abscess Chronic Right tube following miscarriage early 1938
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. at Home	Name of operation Blood Transfusion 4 times
9. Industry or business in which work was done, as saw mill, bank, etc.	What test confirmed diagnosis? — Was there an autopsy? No
10. Date deceased last worked at this occupation (month and year) — 11. Total time (years) spent in this occupation	23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? — Date of injury —, 19
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Henry Co Mo	Where did injury occur? — (Specify city or town, county, and State)
FATHER 13. NAME West Rothgeb	Specify whether injury occurred in industry, in home, or in public place.
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo	Manner of injury —
MOTHER 15. MAIDEN NAME Rose Foster	Nature of injury —
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo	24. Was disease or injury in any way related to occupation of deceased? No
17. INFORMANT Walter C Gaines (ADDRESS) Excelsior Springs, Mo.	If so, specify
18. BURIAL, CREMATION, OR REMOVAL PLACE Crown Hill DATE July 3 1939	(Signed) John F. Grace, M. D.
19. FUNERAL DIRECTOR (NAME) Claude Brickey (ADDRESS) Excelsior Springs, Mo.	(Address) Excelsior Springs Mo
20. FILED July 3 1939 Mrs Ree McCracken, Local Registrar.	

(Licensed Embalmer's Statement on Reverse Side)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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, ...

Claude Richard, or by .....

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

Signed Claude Richard

Licensed Embalmer No. 2751

P. O. Address .....

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, above space should be left blank.