

N. E. 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.

JUN 23 1936

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

Do not use this space.

20013x

1. PLACE OF DEATH

County Mason  
 Township Mason  
 City Hannibal (No Leveaux Hospital)

Registration District No. 247  
 Primary Registration District No. 2079

File No. \_\_\_\_\_  
 Registered No. 150 St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME William J. Gaskill

(a) Residence, No. 1041 Lindell Ave St. \_\_\_\_\_ Ward \_\_\_\_\_  
 (Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Eliza

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 5th 1862

7. AGE YEARS 74 MONTHS 1 DAYS 7 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Farmer  
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.  
 10. Date deceased last worked at this occupation (month and year)  
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) White Hall Ill

13. NAME Clayton Gaskill

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ill

15. MAIDEN NAME Eliza Gaskill

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ill

17. INFORMANT Mr. William Gaskill (ADDRESS) 1041 Lindell Ave. Hannibal, Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Windsberg Cem. DATE 5/14/36

19. UNDERTAKER James O'Donnell (ADDRESS) Hannibal, Mo.

20. FILED May 20 1936 J. C. Guiter Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 12th 1936

22. I HEREBY CERTIFY, That I attended deceased from May 1, 1936, to May 12, 1936

I last saw him alive on May 12, 1936 Death is said to have occurred on the date stated above, at 2:30 p. m.  
 The principal cause of death and related causes of importance were as follows:

Septicemia

Date of onset 5/11/36

Other contributory causes of importance:

Pyelitis - nephritis

Name of operator \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19 \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_

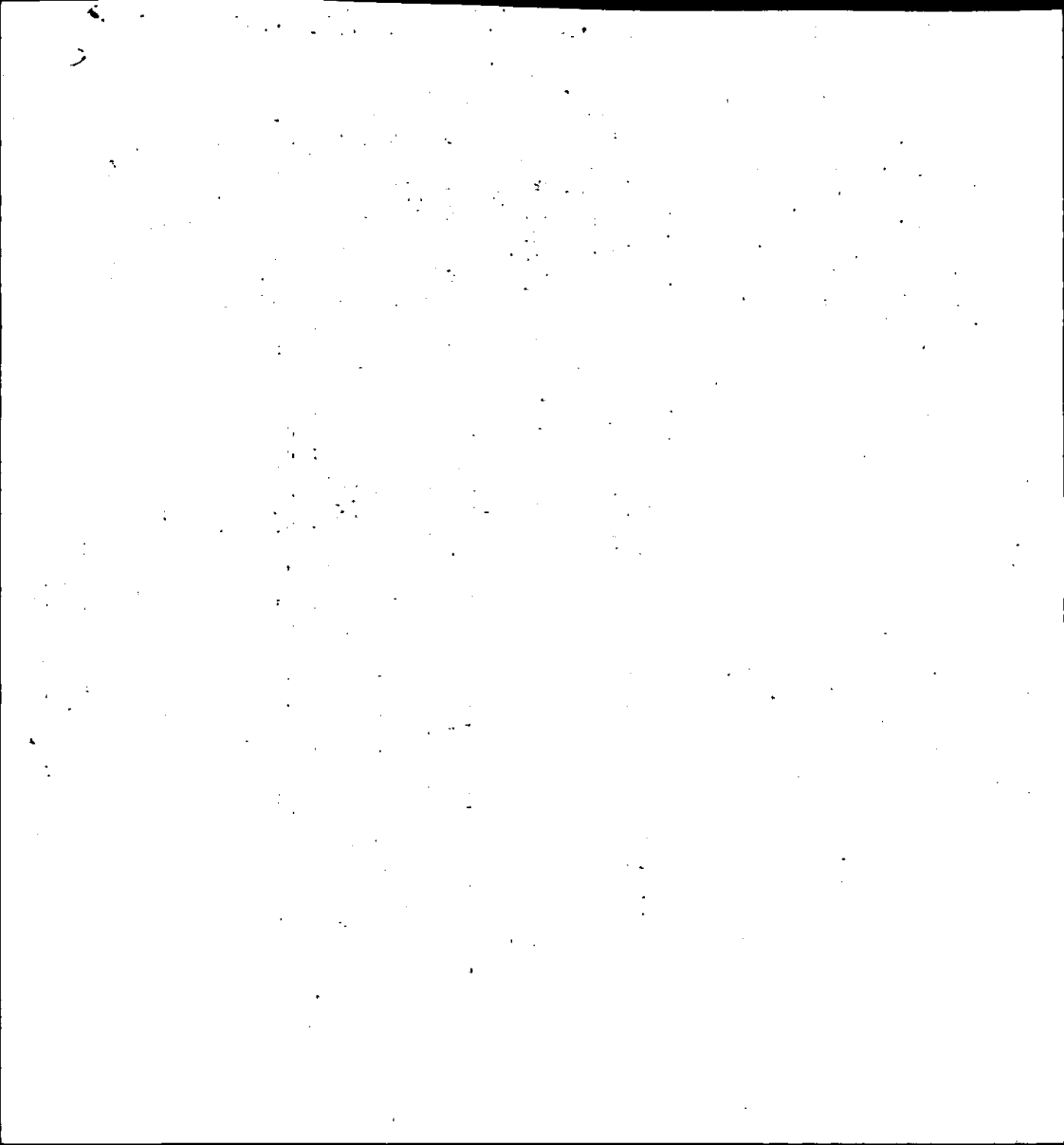
Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_

If so, specify \_\_\_\_\_

(Signed) W. B. Norton, M. D.

(Address) Hannibal, Mo.



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

Do not use this space.

**1. PLACE OF DEATH**

County Marion Registration District No. 547 File No. 20043  
 Township Sammibal Primary Registration District No. 3029 Registered No. \_\_\_\_\_  
 City Sammibal (No. General Wash. St. \_\_\_\_\_ Ward \_\_\_\_\_)

**2. FULL NAME**

(a) Residence, No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
 (Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

**MEDICAL CERTIFICATE OF DEATH**

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Wid.

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May-12-1936

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min. 74 1 7

The principal cause of death and related causes of importance were as follows:

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.  
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.  
 10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_  
 11. Total time (years) spent in this occupation \_\_\_\_\_

Septicemia Date of onset \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

Other contributory causes of importance: Cause of infection unknown

13. NAME \_\_\_\_\_

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

15. MAIDEN NAME \_\_\_\_\_

23. If death due to external causes (violence), fill in also the following: Accident, suicide, homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

17. INFORMANT (ADDRESS) \_\_\_\_\_

Manner of injury \_\_\_\_\_

18. BURIAL, CREMATION, OR REMOVAL PLACE \_\_\_\_\_ DATE \_\_\_\_\_, 19\_\_\_\_

Nature of injury \_\_\_\_\_

19. UNDERTAKER (ADDRESS) \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_

20. FILED Oct 3-1936 Edm. Leck Registrar

(Signed) A. B. Norton, M. D.  
 (Address) Sammibal, Mo.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

**TEMPORARILY  
RECEIVED**

S-20043