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.

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

PLACE OF DEATH

County Dallas

Township Grant

or

Village ~~Louisburg Mo~~

or

City _____ (NO. _____ St.: _____ Ward)

Registration District No. 242 File No. 30787

Primary Registration District No. 5335 Registered No. 6

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Drury Miller Gammon

PERSONAL AND STATISTICAL PARTICULARS

SEX Male

COLOR OR RACE white

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Married

DATE OF BIRTH Aug ~~1841~~ (Month) ~~Aug~~ 1st (Day), 1841 (Year)

AGE 75 yrs. 1 mos. 11 ds. If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work retired

(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE (City or town, State or foreign country) Tenn

PARENTS

NAME OF FATHER Georg P Gammon

BIRTHPLACE OF FATHER (City or town, State or foreign country) Tenn

MAIDEN NAME OF MOTHER Malinda Gilbreath

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Tenn

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W E Gammon

(ADDRESS) Louisburg Mo

Filed Sept 19, 1916 W E Gammon REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Sept (Month) 12 (Day), 1916 (Year)

I HEREBY CERTIFY, that I attended deceased from Aug 1, 1916, to Sept 12, 1916, that I last saw him alive on Sept 12, 1916, and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Cancer of the Stomach

HD

(Duration) ____ yrs. 5 mos. ____ ds.

Contributory (SECONDARY) _____

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) W E Gammon M. D.

Sept 19, 1916 (Address) Louisburg Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL Louisburg Mo

DATE OF BURIAL Sept 13, 1916

UNDERTAKER W. H. Lindsey

ADDRESS Louisburg Mo.

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

PLACE OF DEATH

County _____

Township _____ Registration District No. _____ File No. _____

or

Village _____ Primary Registration District No. _____ Registered No. _____

or

City _____ (NO. _____, _____ St.; _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME _____

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

_____, *1*____
(Month) (Day) (Year)

AGE _____ yrs. _____ mos. _____ ds.

If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____, 191____, _____
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

_____, *191*____
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw h_____ alive on _____, 191____, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

_____

_____

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory _____
(SECONDARY)

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____ M. D.

_____, 191____ (Address) _____

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL _____, 191____
UNDERTAKER	ADDRESS

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.