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: Lawrence

Township: —

or Village: —

or City: Pierce City (NO. ..... St.; ..... Ward)

Registration District No. 471 File No. 2 35601

Primary Registration District No. 16284 Registered No. 1

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

FULL NAME: John Gormen

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: White

~~SINGLE~~ ~~MARRIED~~ WIDOWED ~~OR DIVORCED~~ ~~(Write the word)~~ Wid

DATE OF BIRTH: DK (Month) ..... (Day), 1840 (Year)

AGE: 77 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): —

BIRTHPLACE (City or town, State or foreign country): Ireland

PARENTS
NAME OF FATHER: Dont Know
BIRTHPLACE OF FATHER (City or town, State or foreign country): —
MAIDEN NAME OF MOTHER: dont Know
BIRTHPLACE OF MOTHER (City or town, State or foreign country): —

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ed Gormen

(ADDRESS) Pierce City Mo

Filed Oct 18, 1917. J E Bornhill REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Oct. (Month) 17 (Day), 1917 (Year)

I HEREBY CERTIFY, that I attended deceased from Feb 2, 1917, to Aug 29, 1917, that I last saw him alive on Aug. 29, 1917, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of face

52 44

(Duration) 1 yrs. — mos. — ds.

Contributory (SECONDARY) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E D Wright M. D.

Oct. 18, 1917 (Address) Pierce City, 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: Pierce City Mo

DATE OF BURIAL: Oct 19, 1917

UNDERTAKER: John Seefert

ADDRESS: Pierce City Mo

PLACE OF DEATH

County.....

Township .....
or
Village.....
or
City .....(NO. .....St.:.....Ward)

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

Registration District No.....

Primary Registration District No .....

File No.....

Registered No.....

[If death o
hospital or
give its NA
of street and

Revised United States Standard

FULL NAME.....

PERSONAL AND STATISTICAL PARTICULARS

SEX

COLOR OR RACE

SINGLE
MARRIED
WIDOWED
OR DIVORCED
(*Write* the word)

DATE OF BIRTH

.....(Month) .....(Day), 1.....(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

.....(Month) .....(Day)

I HEREBY CERTIFY, that I attended decea
....., 191...., to.....
that I last saw h.....alive on .....
and that death occurred, on the date stated above, at.
The CAUSE OF DEATH* was as follows:

.....

.....

.....

.....(Duration).....yrs. .....mos.

Contributory.....
(SECONDARY)

.....(Duration).....yrs. .....mos.

(Signed).....

....., 191.... (Address).....

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

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRA
RECENT RESIDENTS)

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

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

Former or usual residence.....

PLACE OF BURIAL OR REMOVAL

DATE OF BU

UNDERTAKER

ADDRESS

"Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("Pneumonia," unqualified, is indefinite);