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: Berry

Township: ~~Wheaton~~ Shoal Creek

or Village:

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

Registration District No.: ~~608~~ 31

Primary Registration District No.: 5044

File No.: ~~201~~ 540

Registered No.: 15

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

FULL NAME John L. E. Ghan

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: White

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word):

DATE OF BIRTH: January 30, 1871 (Month) (Day) (Year)

AGE: 47 yrs. 9 mos. 5 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): 188

BIRTHPLACE (City or town, State or foreign country): Bradley Co Tenn

PARENTS

NAME OF FATHER: Daniel Ghan

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

MAIDEN NAME OF MOTHER: Narvell NK

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): H. S. Ghan

(ADDRESS): Berry Mo

Filed ~~Oct 5th~~ Oct 29, 1918, ~~D. N. Farrell~~ A. J. Clevenger REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Oct 4, 1918 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Oct 3rd, 1918, to Oct 4th, 1918, that I last saw him alive on Oct 4th, 1918, and that death occurred, on the date stated above, at 7:30 p.m.

The CAUSE OF DEATH* was as follows:

Got Killed by a Horse
Head Internal Injuries

2 days Accident (Duration) ..... yrs. ..... mos. ..... ds.

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

(Signed) P. L. Freeland M. D.

~~Oct 5~~ Oct 29, 1918 (Address) Fairview 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: Barry Co Mo (Mercer County)

DATE OF BURIAL: Oct 5th 1918

UNDERTAKER: J H White

ADDRESS: Fairview Mo

PLACE OF DEATH

MISSOURI STATE BOARD OF HEALT
BUREAU OF VITAL STATISTICS
CERTIFICATE 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 i hospital or instituti give its NAME inst 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) (Ye

I HEREBY CERTIFY, that I attended deceased f

....., 191...., to....., 191

that I last saw h.....alive on....., 191

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)..... M

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

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

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

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

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

Former or usual residence.....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
	....., 19
UNDERTAKER	ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD