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

Do not use this space.

40387

1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Primary Registration District No. 003

City Mans (No. City Hospital ..... St. ..... Ward)

File No. .....

Registered No. 12438

2. FULL NAME Wm Gingrich

(a) Residence. No. 221 S Bdway St. 25 Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 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): Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 27 - 1872

7. AGE: Years 54 | Months 7 | Days 27 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): Day
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Indiana

PARENTS

10. NAME OF FATHER: John Gingrich

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Pennsylvania

12. MAIDEN NAME OF MOTHER: Sarah Castle

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Pennsylvania

14. INFORMANT: Hospital Information
(Address) Ft Ross City Hospital

15. FILED DEC 31 1926, 19.. Max C Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 24 1926

17. I HEREBY CERTIFY, That I attended deceased from Dec 23, 1926 to Dec 24, 1926, that I last saw him alive on Dec 24, 1926, and that death occurred, on the date stated above, at 1:55 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Lobar pneumonia

103

101a (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? .....

DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) [illegible] M. D

12/30, 1926 (Address) City Hospital

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: St Trinity Lutheran

DATE OF BURIAL: 12/31 1926

20. UNDERTAKER: Southern N. L. E.

ADDRESS: 7315 S. Bdway

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.

Gingrich