

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

Do not use this space.

1. PLACE OF DEATH

County Jasper
Township Webb City
City Webb City (No. 1)

Registration District No. 417
Primary Registration District No. 3021

File No. 5397
Registered No. 17
St. _____ Ward _____

2. FULL NAME

(a) Residence. No. 509 W. Park 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

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

5a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or) WIFE OF Sarah C. Gayhart

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 11, 1859

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
66 11 12

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Griller
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Missouri

10. NAME OF FATHER

A. Gayhart

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Missouri

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Unknown

14.

INFORMANT Mrs. Sarah C. Gayhart
(Address) Webb City Mo.

15.

FILED 2-14-28 R. M. Stormont
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 13 1928

17. I HEREBY CERTIFY, That I attended deceased from 2-9-28 to 2-13-28 1928

that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____.

THE CAUSE OF DEATH,* WAS AS FOLLOWS:

Cerebral Hemorrhage
82 yrs. 7 mos. 4 da.
1791 (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY)

Arterio Sclerosis
(duration) 10 yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH, _____

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Autopsy

(Signed) J. D. Dunbar, M. D.
13, 1928 (Address) Webb City Mo.

*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

DATE OF BURIAL

Stirling Cemetery 2/15 1928

20. UNDERTAKER

ADDRESS

Webb City Und Co Webb City Mo.

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.

MAR 19 1928

68-11-17

THIS IS A PERMANENT RECORD

nothing be credited applied. AGE should
that it can be properly classified.

RECORD
LX. PHYSICIAN
RECORDATION IN

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Jasper Registration District No. 417 File No. _____
 Township _____ Primary Registration District No. _____ Registered No. 17
 City West City (No. _____) St. _____ Ward _____

2. FULL NAME George Gayhart

(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. _____ da. How long in U.S., if of foreign birth? _____ yrs. _____ mos. _____ da.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar 1 - 1859

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
X 68 X 11 X 12

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Driller
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) _____
 (STATE OR COUNTRY) _____

10. NAME OF FATHER _____

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

12. MAIDEN NAME OF MOTHER _____

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

14.

INFORMANT _____
 (Address) _____

15.

FILED 3/21/28 R. M. Strout
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2 - 12 19 28

17. I HEREBY CERTIFY, That I attended deceased from _____, to _____, 19____, (that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) _____
 (duration) _____ yrs. _____ mos. _____ da.

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) _____, M. D.
 _____, 19____ (Address) _____

*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 _____

DATE OF BURIAL _____

19

20. UNDERTAKER _____

ADDRESS _____

Every item of information should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so as to be readily classifiable, is especially important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

