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

Do not use this space.

672

1. PLACE OF DEATH
County: Clark
Township: Madison
City: ..... (No. ..... St. ..... Ward)
Registration District No.: 190
Primary Registration District No.: 5269
File No.:
Registered No.: 7

2. FULL NAME: Francis Ransom Gingles

(a) Residence. No. ..... St., ... Ward. ..... (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred 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: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

5a. IF MARRIED, ~~WIDOWED, OR DIVORCED~~ HUSBAND OF (OR) ~~WIFE OF~~ Virgina Smith Gingles

6. DATE OF BIRTH (MONTH, DAY AND YEAR): April 3. 1868

7. AGE: Years 65 | Months 9 | Days 12 | 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): " "
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN): Rock Island
(STATE OR COUNTRY): Illinois

PARENTS
10. NAME OF FATHER: Wm. T Gingles
11. BIRTHPLACE OF FATHER (CITY OR TOWN): ..... (STATE OR COUNTRY): Pennsylvania
12. MAIDEN NAME OF MOTHER: Elizabeth E. Johnson
13. BIRTHPLACE OF MOTHER (CITY OR TOWN): ..... (STATE OR COUNTRY): Canada

14. INFORMANT: Virgina Gingles
(Address): St Francisville Mo.

15. FILED: 1/17, 1929 J. R. Bridges, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Jan. 15 1929

17. I HEREBY CERTIFY, That I attended deceased from 1/12, 1929, to 1/15, 1929, that I last saw h. alive on 1-15-29, and that death occurred, on the date stated above, at 3 A.M. ..... m.

THE CAUSE OF DEATH WAS AS FOLLOWS:
(a) Lobar Pneumonia
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..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (SECONDARY): Myocarditis
..... (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) J. R. Bridges, M. D. 1/17, 1929 (Address) Kahoka 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: Sand Cemetery.
DATE OF BURIAL: 1/17 1929
20. UNDERTAKER: Fred J Karle
ADDRESS: Kahoka 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.

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