

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

Do not use this space.

Dr. Barclay
29974
File No. _____
Registered No. *44*
St. _____ Ward _____

1. PLACE OF DEATH

County *W. Lincoln* Registration District No. *198*
Township *Brushington* Primary Registration District No. *3011*
City *Excelsior Springs*

2. FULL NAME

John J. Gavin
(a) Residence No. *114 E. Broad* St., Ward _____
(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

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Married

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

Grace Gavin

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

Dec 15 - 1866

7. AGE

YEARS	MONTHS	DAY	IF LESS than 1 day, _____ hrs. or _____ min.
<i>62</i>	<i>3</i>	<i>12</i>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *Retired farmer*
(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)

Ill.

PARENTS

10. NAME OF FATHER

Don't know

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

Don't know

12. MAIDEN NAME OF MOTHER

Don't know

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

Don't know

14. INFORMANT (Address)

Grace Gavin
Excelsior Springs

15. FILED

3-27-19-29 *W. Crocker*
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *3-27-1929*

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

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Bright's Disease
Diabetes
(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH: _____

19. DID AN OPERATION PRECEDE DEATH? DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) *Chas P Barclay*, M. D.
19____ (Address) *Excelsior Springs MO*

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

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

West Point, Mo.

DATE OF BURIAL

3-29-1929

20. UNDERTAKER

Hubert Hope, Excelsior Springs

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS should state EXACTLY. ROE should be stated EXACTLY. PHYSICIANS should state EXACTLY. PHYSICIANS should state EXACTLY.

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