

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

Do not use this space.

1. PLACE OF DEATH

County..... Registration District No. **791**
1003
Township..... Primary Registration District No.
City **St. Louis** (No. **Lawrence**, City Hospital #1) St. Ward)

File No. **26447**
Registered No. **7703**

2. FULL NAME

Jack Gans
(a) Residence. No. **4910 W. Pine**, St. **12** Ward. (If nonresident, give city or town and State)
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) **Single**

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Not known**

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day,hrs. ormin.
about 29				

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) **Little Rock**
(STATE OR COUNTRY) **Ark.**

10. NAME OF FATHER **Gus M. Gans**

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

12. MAIDEN NAME OF MOTHER **Gertrude Womack**

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

14. INFORMANT **H. K. Becker**
(Address) **Winnetka, Ill.**

15. FILED **25 1929** **M. C. Stanley** REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **July 24th 1929**

17. I HEREBY CERTIFY, That I attended deceased from 19..... to 19..... and that I last saw him alive on 19..... and that death occurred, on the date stated above, at **5:30 P.** m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Gunshot Wound of Head -
Self-Inflicted
1677 (duration) yrs. mos. ds.

CONTRIBUTORY **suicide** (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED **1700**
IF NOT AT PLACE OF DEATH.....

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

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS
(Signed) **J. W. Kerner** M. D.

7/25, 1929 (Address) **Dep. Crow**
*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 **Little Rock Ark.** DATE OF BURIAL **7-25 1929**

20. UNDERTAKER **H. Rindskopf** ADDRESS **546 Felmar**

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

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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