

APR 21 1937

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

Do not use this space.

1. PLACE OF DEATH

 County Dallas
 Township Washington
 City Conway (No.)

 Registration District No. 247
 Primary Registration District No. 5342

 File No. 11722
 Registered No. 7
 St. Ward)

2. FULL NAME

 (a) Residence, No. 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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

 3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED, (write the word) widowed

 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mary Gann
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 21 - 1858
 7. AGE YEARS 78 MONTHS 7 DAYS 4 If LESS than 1 day, hrs. or min.

 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Farmer

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

 12. BIRTHPLACE (CITY OR TOWN) Dallas co. (STATE OR COUNTRY) mo.
13. NAME Silas Gann
 14. BIRTHPLACE (CITY OR TOWN) Gann (STATE OR COUNTRY)
15. MAIDEN NAME Abraham
 16. BIRTHPLACE (CITY OR TOWN) .. (STATE OR COUNTRY) ..

 17. INFORMANT Oscar Gann (ADDRESS) Conway mo

 18. BURIAL, CREMATION, OR REMOVAL PLACE Flora DATE 3-26-37

 19. UNDERTAKER H. B. Jones (ADDRESS) Flora mo

 20. FILED 4-10-1937 H. B. Jones Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3-25-1937
 22. I HEREBY CERTIFY, that I attended deceased from March 24 1937, to March 24 1937. I last saw him alive on March 24 1937. Death is said to have occurred on the date stated above, at 2:30 p.m.

The principal cause of death and related causes of importance were as follows:

Right Lobar
Pneumonia,
1860

 Other contributory causes of importance:
Fracture of neck of
left femur.

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? accident Date of injury Dec 1936Where did injury occur? at home country (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

at home in country

Manner of injury fall

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) O. B. Headley, M. D.(Address) Flora, 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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**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

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1. PLACE OF DEATH

County Saline
Township Washington
City..... (No. St. Ward)

Registration District No. 247
Primary Registration District No. 3342

File No. 11722
Registered No.

2. FULL NAME

John A. Gann

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

PERSONAL AND STATISTICAL PARTICULARS

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

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

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

7. AGE YEARS 75 MONTHS 7 DAYS 4 If LESS than day, hrs. or min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. UNDERTAKER (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE 19

19. UNDERTAKER (ADDRESS)

20. FILED 8-6-8-1937 Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3-28-1937

22. I HEREBY CERTIFY, That I attended deceased from 19....., to 19.....

I last saw him alive on 19..... Death is said to have occurred on the date stated above, at m.

The principal cause of death and related causes of importance were as follows:

Date of onset

Other contributory causes of importance:

Fracture of neck of rt femur

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? Date of injury Dec 1936

Where did injury occur? at home country (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

at home in country

Manner of injury fall

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) O. C. Yeaster, M. D.

(Address) Elkland Mo

SUPPLEMENTARY

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state

5-11722