

RFD JUL 15 1940

Registration District No. 5828

Primary Registration District No. 5828

Registrar's No.

1. PLACE OF DEATH:

(a) County Dade Rural Center  
 (b) City or town Greenfield, Mo.  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
 (If not in hospital or institution, write street number or location) 7  
 (d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
 In this community Many years years, months or days

3. (a) PRINT FULL NAME James P. Gass, 2nd

3. (b) If veteran, name war \_\_\_\_\_ (c) Social Security old age ant. 954 No. 29-954

4. Sex Male 5. Color or race W 6. (a) Single, widowed, married, divorced divorced

6. (b) Name of husband or wife Wife 6. (c) Age of husband or wife if alive 63 years

7. Birth date of deceased Dec 2 1865 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>75</u>	<u>6</u>	<u>26</u>	hr. _____ min.

9. Birthplace Greenfield, Mo. (City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business 1

12. Name Cincero Gass

18. Birthplace Ohio (City, town, or county) (State or foreign country)

14. Maiden name Margaret Costo

15. Birthplace Ohio (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Charles Gass

(b) Address Greenfield, Mo.

17. (a) Burial (b) Date thereof May 26, 40 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenfield Cemetery

18. (a) Signature of funeral director J.W. Ward

(b) Address Greenfield, Mo.

19. (a) 6-16-39 (b) W. L. ... (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Dade  
 (c) City or town Greenfield, Mo. Rural  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_ (If rural, give location)  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 26 year 1940 hour 4 minute 30 P.M.

21. I hereby certify that I attended the deceased from 1-1, 1940, to May 26, 1940; that I last saw him alive on May 20, 1940; and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial Infarction  
Coronary Arteriosclerosis

Due to \_\_\_\_\_

Due to 93 W

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:  
 (a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
 (b) Date of occurrence \_\_\_\_\_  
 (c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? 2-14  
 While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature W. L. ... (M. D. or other)

Address Greenfield, Mo. Date signed 6-30-40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

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.

Cowan

AUG 27 1941

RECEIVED

District Health Officer No. 6,

District File Number.....

RECEIVED

District Health Officer No. 6,

District File Number 640-1474

Date Filed..... JUL 01 1940

JUL 01 1940 July

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed J. W. Ward

Licensed Embalmer No. 2832

P. O. Address Greenfield, Mass.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

State File No. 21606

Registration District No. 237

Primary Registration District No. 5323

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Madison  
(b) City or town Center  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
In this community \_\_\_\_\_ (Specify whether  
years, months or days)

3. (a) PRINT FULL NAME James G. Gass

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Wid

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_

7. Birth date of deceased Dec 2 1865  
(Month) (Day) (Year)

8. AGE: Years 78 Months 6 Days 26 If less than one day \_\_\_\_\_ min.

9. Birthplace 78-5-24  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) 6-1-1940 (b) Geo. R. Weir  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_  
(If outside city or town limits write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 26  
year 1940 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature H. O. Cowan (M. D. or other) \_\_\_\_\_  
Address Greenfield \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

