

17-39  
K21492

**JAN 25 1941**

Registration District No. **253** Primary Registration District No. **5354** Registrar's No. \_\_\_\_\_

**1. PLACE OF DEATH:**

(a) County **Daviess**  
(b) City or town **"Rural" Harrison Township**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**3 Miles North West Breckenridge,**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community **1 Year** \_\_\_\_\_  
years, months or days **2**

8. (a) PRINT FULL NAME **Mary Savannah Gann**

3. (b) If veteran, name war **None** 3. (c) Social Security No. **None**

4. Sex **Female** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **John Logan Gann** 6. (c) Age of husband or wife if alive **Unk.** years

7. Birth date of deceased **June 27 1868**  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
**72 4 26** hr. min.

9. Birthplace **Daviess County Missouri**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

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

MOTHER FATHER  
12. Name **Eli Culver**  
18. Birthplace **Daviess County Missouri**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Elizabeth Leabo**  
15. Birthplace **Ray County Missouri**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Addie McCrary**  
(b) Address **Breckenridge, Mo.**

17. (a) **Burial** (b) Date thereof **11-26-40**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **McCrary Cemetery**

18. (a) Signature of funeral director **Hope Fun. & Undt. Co**  
(b) Address **Gallatin, Mo.**

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State **Missouri** (b) County **Daviess**  
(c) City or town **"Rural" Harrison Township**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **3 Miles N. W. Breckenridge, Mo**  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month **November** day **23**  
year **1940** hour **11** minute **00** P. M.

21. I hereby certify that I attended the deceased from **Nov. 20th 1940** to **Nov. 23rd 1943**,  
that I last saw her alive on **Nov 23rd 1940**,  
and that death occurred on the date and hour stated above.

Immediate cause of death **Acute carditis** Duration  
**2yrs**

Due to **Carcinoma of lungs and hip.**

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

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

PHYSICIAN  
Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

**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? \_\_\_\_\_

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

28. Signature **A. R. Wilcox** (M. D. or other) \_\_\_\_\_  
Address **Breckenridge, Mo** Date signed **Dec 6-40**

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

47

**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 L. O. Richesson

Licensed Embalmer No. 3302

P. O. Address Gallatin, Mo.

**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

State File No. 42341

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 253

Primary Registration District No. 535-4

Registrar's No. ....

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

1. PLACE OF DEATH:

(a) County Daviess  
(b) City or town Harrison T.O.  
(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..... (Specify whether  
In this community..... (Specify whether  
years, months or days)

3. (a) PRINT FULL NAME Mary Savannah Gamm  
(b) If veteran, name war..... (c) Social Security No.....

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced.....  
7. Birth date of deceased..... (Month) (Day) (Year)

8. (b) Name of husband or wife..... 6. (c) Age of husband, or wife, if alive..... years

8. AGE: Years Months Days If less than one day  
72 4 26 hr. min.

9. Birthplace..... (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..... (Month) (Day) (Year)

(c) Place: burial or cremation.....

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

(b) Address.....

19. (a)..... (b)..... (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.

20. DATE OF DEATH: Month Nov day 23 year 1940 hour..... minute..... M.

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

Immediate cause of death Acute Carditis Duration

Carcinoma of lung and  
Due to hyp

Due to to carcinoma of lung  
hyp and general atrophy

Other conditions..... (Include pregnancy within 3 months of death)

Major findings: Primary lung  
Of operations.....

Of autopsy..... 45

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?

..... (Specify type of place)

While at work?..... (e) Means of injury.....

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

Address..... Date signed.....

SUPPLEMENTAL

MEDICAL CERTIFICATION

PHYSICIAN

Underline the cause to which death should be charged statistically.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

State File No. 42341

Registration District No. 253

Primary Registration District No. 2387

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

1. PLACE OF DEATH:

(a) County Dairless  
(b) City or town Farrison, T.P.  
(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 \_\_\_\_\_ (Specify whether  
In this community \_\_\_\_\_ (Specify whether  
years, months or days)

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.

3. (a) PRINT FULL NAME

Mary Savannah Gannon

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex F

5. Color or race w

6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased \_\_\_\_\_ (Month) (Day) (Year)

8. AGE: Years 72 Months 4 Days 26 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (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 \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)

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

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

(b) Address Loer Springs

19. (a) 12 (b) J. B. Thibault, M.D.  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Month 11 day 23  
year 1940 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw h\_\_\_\_\_ 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 A. B. Wilson (M. D. or other) \_\_\_\_\_

Address Brookridge Date signed Nov

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTAL

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

MOTHER FATHER