

FILED MAY 12 1945
Registration District No. 2188

Primary Registration District No. 3054

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Pike
(b) City or town Louisiana
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
805 North 7th St.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community thirty years. (years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Pike 82
(c) City or town Louisiana 7
(If outside city or town limits, write "RURAL") 1
(d) Street No. 805 North 7th St.
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Cavellon Wilber Gant

3. (b) If veteran, name war no 3. (c) Social Security No. _____

4. Sex Male (M) 5. Color or race white 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Lena Gant 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Jan 23 1867
(Month) (Day) (Year)

8. AGE: Years 78 Months 3 Days 5 If less than one day _____ hr. _____ min.

9. Birthplace Brookville Ill.
(City, town, or county) (State or foreign country)

10. Usual occupation Labour

11. Industry or business _____

MOTHER FATHER
12. Name Ruban Gant
13. Birthplace Unknown 9
(City, town, or county) (State or foreign country)
14. Maiden name Clara Pahl
15. Birthplace Unknown 9
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. C.W. Gant
(b) Address Louisiana, Mo.

17. (a) Burial (b) Date thereof 4/30/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Louisiana, Mo.

18. (a) Signature of funeral director James + Stone

(b) Address Louisiana, Mo.

19. (a) 4-30-45 (b) J. C. Haley
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 28
year 1945 hour 6:15 minute _____ A. M.

21. I hereby certify that I attended the deceased from 4-21, 1945 to 4-27 1945

that I last saw him alive on 4-27 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage

Due to arteriosclerosis

Due to _____

Other conditions (Includes pregnancy within 3 months of death) 30

Major findings: Of operations none

Of autopsy none

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

(a) Accident, suicide, or homicide (specify) none

(b) Date of occurrence none

(c) Where did injury occur? none
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? none
(Specify type of place) (e) Means of injury none

23. Signature J. C. Haley (M. D. optional)
Address Louisiana, Mo. Date signed 4-28-45

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

1-2020

RECEIVED
District Health Officer No. 10
District File Number 5-45-773
Date Filed MAY 10 1945

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. B. Stern
Licensed Embalmer No. 4039
P. O. Address Louisiana, 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, fact should be so stated above.