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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

FILED NOV 8 1945

STANDARD CERTIFICATE OF DEATH

State File No. 33050

Registration District No. 20

Primary Registration District No. 5082

Registrar's No.

1. PLACE OF DEATH:

(a) County Bates  
(b) City or town Rural-Grand River Twp.  
(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 \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Bates  
(c) City or town Rural Grand River Twp.  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME David Nathan Gann

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

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

6. (b) Name of husband or wife Naomi Gann 6. (c) Age of husband or wife if alive Deceased

7. Birth date of deceased January 28 1870  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
75 7 3 hr. min.

9. Birthplace Cedar Co., Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

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

12. Name James H. Gann

13. Birthplace Livingston Co., Missouri  
(City, town, or county) (State or foreign country)

14. Maiden name Breeze

15. Birthplace Livingston Co., Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Vernon Gann

(b) Address Adrian Mo.

17. (a) Burial (b) Date thereof 9-2-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Crescent Hill Cem

18. (a) Signature of funeral director Creath + Dix

(b) Address Adrian Mo.

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 31  
year 1945 hour 9 minute 40 P. M.

21. I hereby certify that I attended the deceased from Apr. 24 1944 to Aug. 31 1945  
that I last saw him alive on July 10 1945  
and that death occurred on the date and hour stated above.

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

Chronic myocarditis  
Due to Chronic nephritis

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

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

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

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

Duration

PHYSICIAN

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? \_\_\_\_\_

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

23. Signature Cartey W. Lyles (M. D. or other) MD  
Address Bates Mo Date signed 9/4/45

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

MOTHER FATHER

1299

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

Office No. 7,  
10-45-1031  
Date Recd. 11-7-45

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 *and*

*Fred J. Greath 3343*, Registered Apprentice No. \_\_\_\_\_

working under my personal supervision.

Signed *leddy*

Licensed Embalmer No. *3650*

P.O. Address: *Adrian 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.

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. 200Registration District No. 20Primary Registration District No. 5082Registrar's No. 13

## 1. PLACE OF DEATH:

(a) County Bates  
(b) City or town Rural Grand River  
(c) Name of hospital or institution: gap

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_  
years, months or days3. (a) PRINT FULL NAME David N. Lauer3. (b) If veteran,  name war \_\_\_\_\_ 3. (c) Social Security No. gap4. Sex M 5. Color of 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 \_\_\_\_\_ years

7. Birth date of deceased Jan 28 (Month) (Day) (Year)8. AGE: Years 75 Months 7 Days no If less than one day \_\_\_\_\_ 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 \_\_\_\_\_

19. (a) 9-6-45 (b) Myra Owens (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) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan Year 1945 Hour \_\_\_\_\_ Minute \_\_\_\_\_ M.21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_  
and the death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

Duration

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

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

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

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

PHYSICIAN

Underline  
the cause to  
which death  
should be  
charged sta-  
tistically.

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) (c) Means of injury \_\_\_\_\_

23. Signature Carter W. Luter (M. D. or other) \_\_\_\_\_Address Butler Mo Date signed 9-4-45

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

SUPPLEMENTARY

33050