

No. 2
-12-45
-17-39
X47070

FILED OCT 21 1947
Registration District No. **316**

Primary Registration District No. **4462**

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

1. PLACE OF DEATH:

(a) County **St. Francois**
 (b) City or town **Elvins, 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)
 (d) Length of stay: In hospital or institution. (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Ida May Gant**
 3. (b) If veteran, name war. 3. (c) Social Security No.

4. Sex **Female** 5. Color or race **w**
 6. (a) ~~Single~~ ~~widowed~~ ~~married~~ ~~divorced~~
 6. (b) Name of husband or wife **James D. Gant**
 6. (c) Age of husband or wife if alive **76** years
 7. Birth date of deceased **NOV 1 - 1870**
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
76 11 5 hr. min.

9. Birthplace **Marion county, MO**
 (City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business

12. Name **John Shaw**

13. Birthplace **Marion County, MO**
 (City, town, or county) (State or foreign country)

14. Maiden name **Mary Slater**

15. Birthplace **Marion County, MO**
 (City, town, or county) (State or foreign country)

16. (a) Informant **James D. Gant**
 (b) Address **Elvins, MO**

17. (a) **Burial** (b) Date thereof **Oct-8-47**
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Greenley Ceme - Sparks**
 18. (a) Signature of funeral director **Sparks**
 (b) Address **Flat River, MO**

19. (a) **10-11-47** (b) **Ether Rudloff**
 (Date received local report) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St. Francois 94**
 (c) City or town **ELVINS**
 (If outside city or town limits, write "RURAL")
 (d) Street No. (If rural, give location)
 (e) Citizen of foreign country? **NO** (Yes or No)
 If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct** day **6** TR
 year **1947** hour **7:10** minute **P** M.

21. I hereby certify that I attended the deceased from **Sept. 10**, 19**46** to **Oct 6**, 19**47**
 that I last saw h. **u** alive on **Oct 6**, 19**47**
 and that death occurred on the date and hour stated above.

Immediate cause of death
Phoplexy
hypertensive renal
disease

Due to **Phoplexy**
hypertensive renal
disease

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
 Of operations **ggs**
 Of autopsy

Duration **2 days**
10 yrs.

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

23. Signature **J. O. Shephard** (M. D. or other)
 Address **Flat River, Mo.** Date signed **10-10-47**

ED

District Health Officer No. 4

District File Number 1047-1344

Date Filed 7-20-47

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 Murphy L Sparks
Licensed Embalmer No. 4236
P. O. Address Flat River, 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.