

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

42442

State File No.

FILED JAN 5 - 1954

BIRTH NO. _____ REG. DIST. NO. 96 PRIMARY REG. DIST. NO. 5314 Registrar's No. 1

1. PLACE OF DEATH a. COUNTY <u>DALLAS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Dallas</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>CONWAY RR 2</u>	c. LENGTH OF STAY (In this place) <u>Life</u>	c. CITY (If outside corporate limits, write RURAL and give township) <u>Conway RR 2</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If rural, give location) <u>0300</u>	
3. NAME OF DECEASED a. (First) <u>MARION</u> b. (Middle) <u>JOSEPH</u> c. (Last) <u>GANN</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>12 22 1953</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <u>9-16-1880</u>
9. AGE (In years last birthday) <u>73</u>		10. MONTHS <u>3</u>	10. DAYS <u>6</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Missouri</u>
13a. FATHER'S NAME <u>Francis Gann</u>		13b. MOTHER'S MAIDEN NAME <u>Fane Alley</u>	14. NAME OF HUSBAND OR WIFE <u>May</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war and dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME <u>May Potts Gann</u> ADDRESS <u>Conway Mo</u>
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Myocarditis</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Arteriosclerosis T.B.</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>12-19-1953</u> , to <u>12-22-1953</u> , that I last saw the deceased alive on <u>12-22-1953</u> , and that death occurred at _____ m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <u>J. W. Lindsey MD</u>		23b. ADDRESS <u>Conway</u>	
23c. DATE SIGNED <u>12-24-53</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>12-24-1953</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Gann</u>	24d. LOCATION (City, town, or county) (State) <u>Dallas Co Mo</u>
DATE REC'D BY LOCAL REG. <u>1-2/54</u>	REGISTRAR'S SIGNATURE <u>Ernest Potts</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>R B Bruce</u> ADDRESS <u>Buffalo Mo</u>	

300

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

JAN 8 1952

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.....

..... Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed *Leonard B. Jones*

Licensed Embalmer No. *2508*

P. O. Address *Buffalo N.Y.*

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.