

FILED NOV 23 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **36920**

BIRTH NO. _____ REG. DIST. NO. 96 PRIMARY REG. DIST. NO. 5353 Registrar's No. 75-

1. PLACE OF DEATH a. COUNTY <u>DALLAS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before of institution). a. STATE <u>Missouri</u> b. COUNTY <u>Dallas</u>	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <u>ELKLAND RR</u>) c. LENGTH OF STAY (In this place) <u>Life</u>		c. CITY OR TOWN <u>Elkland RR</u> d. Is Residence within limits of city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION		e. STREET ADDRESS (If rural, give location) <u>0200</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>LYDIA</u> b. (Middle) <u>ANN</u> c. (Last) <u>DILL</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>11-8-1954</u>		
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5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>5-28-1875</u>		9. AGE (In years last birthday) <u>79</u> If UNDER 1 YEAR: Months <u>5</u> Days <u>10</u> If UNDER 1 HR. Hours <u>10</u> Min.	
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10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) <u>Dallas Co Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
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13a. FATHER'S NAME <u>W. M. Gann</u>		13b. MOTHER'S MAIDEN NAME <u>Kane Gann</u>		14. NAME OF HUSBAND OR WIFE <u>John</u>	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME <u>John Dill Elkland</u> ADDRESS <u>Mo.</u>	
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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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary thrombosis</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Bronchial Asthma</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>?</u>	
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19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Buffalo Mo</u>	
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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"/>		21f. HOW DID INJURY OCCUR?	
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22. I hereby certify that I attended the deceased from 11-6, 1954, to 11-8, 1954, that I last saw the deceased alive on 11-8, 1954, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE <u>P. O. Gannon</u> (Degree or title) <u>M.D.</u>		23b. ADDRESS <u>Buffalo Mo</u>		23c. DATE SIGNED <u>11-19-54</u>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>11-10-1954</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Mt Olive</u>		24d. LOCATION (City, town, or county) (State) <u>Dallas Co Mo</u>	
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DATE REC'D BY LOCAL REG. <u>11-20-54</u>		REGISTRAR'S SIGNATURE <u>Ernest Peterson</u>		25. FEDERAL DIRECTOR'S SIGNATURE <u>R B Jones</u> ADDRESS <u>Buffalo Mo</u>	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEC 27 1954

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.....
Signature of Student Embalmer

Signed *Mary B. Jones*.....

Licensed Embalmer No. *432*

P. O. Address *Buffalo*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.