

FILED OCT 21 1957

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 958-A

S. 300
1-57

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Laclede</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>CONWAY</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Springfield Baptist Hospital</u>		Length of stay in lb <u>1 year</u>	d. STREET ADDRESS (If outside, give location) <u>SPRINGFIELD BAPTIST HOSPITAL</u> Reside on Form Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>THOMAS GANN</u>			4. DATE OF DEATH Month Day Year <u>10-3-1957</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-22-1873</u>
9. AGE (In years last birthday) <u>84</u>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>retired</u>	11. BIRTHPLACE (City and state or country) <u>DALLA Co. Mo.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13a. FATHER'S NAME <u>Thomas Gann</u>	
13b. MOTHER'S MAIDEN NAME <u>Rebecca Albee Myrtles</u>		14. NAME OF HUSBAND OR WIFE <u>Mrs Myrtles Gann</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>	17. INFORMANT Address <u>Mrs Myrtles Gann Conway Mo</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GENERALIZED FECAL PERITONITIS</u>			INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u>
Conditions, if any, which gave rise to above cause (a), starting the underlying cause last. DUE TO (b) <u>RUPTURE OF SIGMOID COLON</u>			<u>ABOUT 5</u>
DUE TO (c) <u>OBSTRUCTION FROM CARCINOMA OF RECTUM</u>			<u>154X DAYS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>LONG HISTORY OF RECTAL BLEEDING UNTREATED.</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>9-27-1957</u> to <u>10-3-1957</u> and last saw her/him alive on <u>10-7-1957</u> Death occurred at <u>10:42 PM</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>J. H. Allen M.D.</u>		22b. ADDRESS <u>Springfield Mo</u>	
22c. DATE SIGNED <u>9 Oct 1957</u>		23a. LOCATION (City, town, or county) (State) <u>Dallas Co Mo</u>	
23b. DATE <u>10-5-1957</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gann</u>	
23d. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24. FUNERAL DIRECTOR ADDRESS <u>R B Jones Buffalo Mo</u>	
25. DATE RECD. BY LOCAL REG. <u>10-15-57</u>		26. REGISTRAR'S SIGNATURE <u>Smith Williams</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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 

Licensed Embalmer No. *2502*

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