

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

97570-57

916

FILED JAN 6 1958

STATE FILE NUMBER

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 4

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO b. COUNTY LACHEDE	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN SPRINGFIELD MO		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN CONWAY MO
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BURGE		Length of stay in lb 3 DAYS	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last LINDA JO GANN			4. DATE OF DEATH Month Day Year JAN 1 1958
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC 30 1957
9. AGE (In years last birthday)		FUNDER 1 YEAR Months Days Hours Min. 2	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHILD		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) MISSOURI
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME CECIL GANN	
13b. MOTHER'S MAIDEN NAME BETTY MILLER		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	17. INFORMANT Address CECIL GANN CONWAY MO
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity (118 6 3/4) 2 1/2 weeks gestation DUE TO (b) Premature labor DUE TO (c) Urinary tract infection of mother and premature rupture of bag of waters			INTERVAL BETWEEN ONSET AND DEATH 2 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 76 99			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 WORK <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 12/30/57 to 1/1/58 and last saw her/him alive on 1/1/58 . Death occurred at 7:35 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) J. M. McDowell MD		22b. ADDRESS Marshfield, MO	22c. DATE SIGNED 1/2/58
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 1-2-1958	23c. NAME OF CEMETERY OR CREMATORY GRACELAND	23d. LOCATION (City, town, or county) (State) CONWAY MO
24. FUNERAL DIRECTOR BARBER-EDWARDS MARSHFIELD		25. DATE RECD. BY LOCAL REG. 1-3-58	26. REGISTRAR'S SIGNATURE Edith Williams

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Not Embalmed*

Licensed Embalmer No.....
P. O. Address.....

**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.**