

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-024904

STATE FILE NUMBER

FILED AUG 6 1958 Registration District No. 68 Primary Registration District No. 4119 Registrar's No. 77

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| 1. PLACE OF DEATH a. COUNTY Christian | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo Christian | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Ozark, Mo | | c. CITY OR TOWN Ozark, Mo 0220 0 | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Residence | | Length of stay in 1b 2 years | |
| | | d. STREET ADDRESS Ozark Mo (If outside, give location) | |
| | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |

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|------------------------------------------------------|----------|-------------|----------------------------------------------------------------------|-----|------|
| 3. NAME OF DECEASED (Type or print) Robert | | | 4. DATE OF DEATH Month July Day 18 Year 1958 | | |
| First | Middle | Last | Month | Day | Year |
| | 0 | Gann | | | |

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|-------------------------|----------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|----------------------------------------------|-------------------------------------------|--------------------------------|
| 5. SEX Male 0 | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH July 19-1893 | 9. AGE (In years last birthday) 64 | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Hours Min. |
|-------------------------|----------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|----------------------------------------------|-------------------------------------------|--------------------------------|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) Mo | 12. CITIZEN OF WHAT COUNTRY? U S A |
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|-----------------------------------------|--------------------------------------------|
| 13. FATHER'S NAME Thomas Gann | 14. MOTHER'S MAIDEN NAME Unknown |
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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) NO | 16. SOCIAL SECURITY NO. | 17. INFORMANT Mrs Eula Gann, Ozark, Mo |
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| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Perforated duodenal ulcer | | INTERVAL BETWEEN ONSET AND DEATH 3 days |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | |
| DUE TO (b) | | |
| DUE TO (c) | | 5411 |

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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
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| 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.) |
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|-------------------------------------------------------------|-------------------------------------------------------------------------------------------|---------------------------------------------|--------|-------|
| 20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m. | 20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 20e. CITY, TOWN, OR LOCATION 5411 | COUNTY | STATE |
|-------------------------------------------------------------|-------------------------------------------------------------------------------------------|---------------------------------------------|--------|-------|

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| 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 |
|------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|------------------------------|--------|-------|

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| 21. I attended the deceased from 15 July 1958 to 18 July 1958 and last saw ^{her-} _{him} alive on 15 July 1958 Death occurred at 7:30 A m on the date stated above; and to the best of my knowledge, from the causes stated. | |
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| 22a. SIGNATURE D. Roper | (Degree or title) M. D. | 22b. ADDRESS Ozark, Mo | 22c. DATE SIGNED 22 July 1958 |
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|------------------------------------------------------------|-----------------------------|--------------------------------------------------------------|-----------------------------------------------------------|----------------------|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 7/20/58 | 23c. NAME OF CEMETERY OR CREMATORY Monger Cemetery | 23d. LOCATION (City, town, or county) Christian | (State) Mo |
|------------------------------------------------------------|-----------------------------|--------------------------------------------------------------|-----------------------------------------------------------|----------------------|

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|----------------------------------------------|----------------------------|-----------------------------------------------------|----------------------------------------------------|
| 24. FUNERAL DIRECTOR F. B. Chaffin | ADDRESS Ozark Mo | 25. DATE RECD. BY LOCAL REG. July 30-1958 | 26. REGISTRAR'S SIGNATURE Luetta Leonard |
|----------------------------------------------|----------------------------|-----------------------------------------------------|----------------------------------------------------|

(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare Public Service
2201
300
1-56
All symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
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. Coroner cannot certify to a death due to natural causes.

MEDICAL CERTIFICATION

59 C

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 *T. B. Chaffin*.....

Licensed Embalmer No. *219*

P. O. Address *Ozark*

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.