

R I DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-028821

FILED VS AUG 24 1959

133

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 100

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY Harrison b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Gilman City Length of stay in 1b 62 yr c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION at home Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Harrison c. CITY OR TOWN Gilman City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) no number Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First CHARLES Middle WESLEY Last GANNON				4. DATE OF DEATH Month A Day 13 Year 1959							
5. SEX male		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 3-10-97		9. AGE (last birthday) 62		IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer Trucker				10b. KIND OF BUSINESS OR INDUSTRY XXXXXX		11. BIRTHPLACE (City and state or country) Harrison County, Mo., U.S.		12. CITIZEN OF WHAT COUNTRY			
13a. FATHER'S NAME W. A. GANNON				13b. MOTHER'S MAIDEN NAME WILLFREDA REECE				14. NAME OF HUSBAND OR WIFE NONE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) DO NOT KNOW				16. SOCIAL SECURITY NO. 47-24-6370		17. INFORMANT JOHN GANNON; GILMAN CITY, MO. Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH 6 hr			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) none								PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
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.) Natural							
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____		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 _____ to _____ and last saw her/him alive on _____. Death occurred at 4:00 P am on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE <i>Bethany D.O.</i> (Degree or title)				22b. ADDRESS BETHANY, MO.				22c. DATE SIGNED 8-15-59			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 8-15-59		23c. NAME OF CEMETERY OR CREMATORY Coffey				23d. LOCATION (City, town, or county) Coffey, Mo.			
24. FUNERAL DIRECTOR M. B. HAAS. BETHANY, MO. ADDRESS				25. DATE RECD. BY LOCAL REG. 8-15-1959				26. REGISTRAR'S SIGNATURE <i>Gella Moxey</i>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed MB Haas

Licensed Embalmer No. 3899

P. O. Address Bethany 7

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.