

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

Do not use this space.

22396

9

**PLACE OF DEATH**

County *Darwin*  
Township *Jackson*  
City *(No)*

Registration District No. *253*  
Primary Registration District No. *327*

File No. \_\_\_\_\_  
Registered No. \_\_\_\_\_  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

*Anna Franklin Gay*

(a) Residence No. \_\_\_\_\_ St. \_\_\_\_\_  
(Usual place of abode) \_\_\_\_\_ Ward \_\_\_\_\_

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX *Female* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *widow*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Jas Gay*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Oct. 17-1840*

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<i>89</i>	<i>9</i>	<i>3</i>	

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work *Home*  
(b) General nature of industry, business, or establishment in which employed (or employer) *Home*  
(c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) *Ohio*

10. NAME OF FATHER *Nathan Gilbert*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) *Ohio*

12. MAIDEN NAME OF MOTHER *Anna Dunlap*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) *Ohio*

14. INFORMANT *Laura Wilkinson* (Address) *Janesport, Mo.*

15. FILED *July 30 1930* *W. J. Minnich* REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

*2* 16. DATE OF DEATH (MONTH, DAY AND YEAR) *July 20 1930*

17. I HEREBY CERTIFY, That I attended deceased from *June 5<sup>th</sup>* 19*30*, to *July 19<sup>th</sup>* 19*30*, that I last saw *her* alive on *July 19<sup>th</sup>* 19*30*, and that death occurred, on the date stated above, at *812, 45<sup>th</sup>* m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

*cerebral thrombosis*  
*827*  
*740* (duration) yrs. *1* mos. *19* ds.  
CONTRIBUTORY (SECONDARY) *coma* (duration) yrs. \_\_\_\_\_ mos. *2* ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH: *at home*

DID AN OPERATION PRECEDE DEATH? *no* DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS? *Physical Examination*  
(Signed) *P. V. Thompson*, M. D.  
*7/20, 1930* (Address) *Janesport, Mo.*

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *D. O. O. F. Janesport* DATE OF BURIAL *7/21-1930*

20. UNDERTAKER *H. H. Hays* ADDRESS *Gallatin*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

*26 1930*

