

REC'D JUN 14 1939

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

19583
Do not use this space.

1. PLACE OF DEATH

(a) County Ray Registration District No. 914
 (b) Township Hope Grove Primary Registration District No. 6233 Registered No. 5
 (c) City _____ (d) Street No. _____ St. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Dr. Willard E. Gant

(a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Dora E. Osborn Gant

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug 12, 1859

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
79 8 22

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Doc. Co.
 9. Industry or business in which work was done, as saw mill, bank, etc. _____
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation 0

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) North 0

13. NAME William Gant

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

15. MAIDEN NAME Sarah McLaugh

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

17. INFORMANT (ADDRESS) Mrs. Dr. Gant Stett Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE new Hope DATE May 6 1939

19. FUNERAL DIRECTOR (ADDRESS) Geo. W. Rumpsheld Hardin Mo.

20. FILED May 5 1939 W. E. Gant Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 4 1939

22. I HEREBY CERTIFY, That I attended deceased from May 4, 1939, to May 4, 1939. I last saw him alive on May 4, 1939. Death is said to have occurred on the date stated above, at 4:00 P. m.
 The principal cause of death and related causes of importance were as follows:

Cerebral hemorrhage
Diabetes mellitus
 Date of onset May 4, 39

Name of operation _____ Date of _____
 What test confirmed diagnosis? Amical + Lab. Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased?
 If so, specify No
 (Signed) Carl H. Reed M.D. Hardin Mo.
669 (Address) _____

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

STATEMENT BY LICENSED EMBALMER

I, Embalmed

Licensed Embalmer No. 2789

hereby certify that the body recorded on the reverse side of this certificate was embalmed by

John W. Knipschild

L. E.

No. _____ or by _____
working under my personal supervision.

Registered Apprentice No. ~~2787~~

Signed John W. Knipschild

Licensed Embalmer No. _____

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.)