

ED JAN 17 1941

448

Primary Registration District No. 4266

Registrar's No. \_\_\_\_\_

53

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Laclede

(b) City or town Conway  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_ years, months or days

3. (a) PRINT FULL NAME John Gann

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex male

5. Color or race white

6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Jude Gann

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased april 8 1862  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>78</u>	<u>8</u>	<u>10</u>	hr. min.

9. Birthplace Dallas Co  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER {

12. Name Dent Knorr

13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

14. Maiden name Dent Knorr

15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant Ray Montgomery

(b) Address Conway Mo

17. (a) burial (b) Date thereof 12 19 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Grace Land Cem. Conway Mo

18. (a) Signature of funeral director W.E. Holman

(b) Address Lebanon Mo

19. (a) 1-8-41 (b) Grace Price  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Laclede

(c) City or town Conway  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 18  
year 1940 hour 12 minute 20 P. M.

21. I hereby certify that I attended the deceased from 6-9-1942 to 12-18-1940  
that I last saw him alive on 12-6-1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Valvular Heart Disease

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions  (Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? 407

While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_

23. Signature D. C. Burman (M. D. or other) \_\_\_\_\_  
Address Conway Mo Date signed 1-8-41

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 7,

District File Number 1-41-128

Date Filed 1-14-41

---

---

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.....  
Myself....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....W E Holman.....

Licensed Embalmer No. 4107

P. O. Address Lebanon Mo

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 this body is not embalmed, fact should be so stated above.

Registration District No. 448

Primary Registration District No. 4266

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Ragland  
(b) City or town Conway  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: \_\_\_\_\_  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME John Gann  
3. (b) If veteran \_\_\_\_\_ name war \_\_\_\_\_  
3. (c) Social Security No. \_\_\_\_\_

4. Sex m 5. Color or race w  
6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ year \_\_\_\_\_

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 88 Months 8 Days 10 If less than one day hr. min.

9. Birthplace don't know (City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name \_\_\_\_\_

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) 1-8-41 (b) Grace Price (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH month Dec day 18  
year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw h \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_ Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature J.C. Benson (M. D. or other)

Address Conway mo Date signed \_\_\_\_\_

SUPPLEMENTARY

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

R

S-42987