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.

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

15719

PLACE OF DEATH

County: Daviess

Township or Village or City: Jamesport

Registration District No. 252 — File No.

Primary Registration District No. 5354 — Registered No. 8

(NO. ____ St.: ____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Geo W. Gilliland

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: White

SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

DATE OF BIRTH: Dec 21 1847 (Month) (Day) (Year)

AGE: 66 yrs. 5 mos. 12 ds.

If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): Farming

BIRTHPLACE (City or town, State or foreign country): Ross Co Ohio ~~Jamesport~~ ~~Daviess Co Mo~~

PARENTS

NAME OF FATHER: Nathan Gilliland

BIRTHPLACE OF FATHER (City or town, State or foreign country): Pocahontas Co W Va

MAIDEN NAME OF MOTHER: Annie Dunlap

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Chillicothe ~~W Va~~ Ross Co

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Andrew Jamesport Mo (Informant)

(ADDRESS) Mrs Ross Nichols

Filed May 7 1914. C J McKinley REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2

DATE OF DEATH: Apl. (Month) 24 (Day), 1914 (Year)

I HEREBY CERTIFY, that I attended deceased from Apl. 7, 1914, to Apl. 24, 1914, that I last saw him alive on Apl. 24, 1914, and that death occurred, on the date stated above, at 9P m.

The CAUSE OF DEATH* was as follows:

Pernicious Anaemia
7148
1186 54

(Duration) ____ yrs. 3 mos. ____ ds.

Contributory (SECONDARY) Atrophy of Mucous membrane of Stomach (Duration) ____ yrs. ____ mos. ____ ds.

(Signed) H. V. Thompson M. D.

Apl 25 1914 (Address) Jamesport Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL: Hill Cemetery

DATE OF BURIAL: April 26 1914

UNDERTAKER: J. O. Burrow

ADDRESS: Jamesport

Revised United States Standard Certificate

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

PLACE OF DEATH

County Daviess Co

Township _____ or Village _____ or City _____ (NO. _____ St.: _____ Ward)

Registration District No. _____ File No. _____

Primary Registration District No. _____ Registered No. _____

[If death occurred hospital or instit give its NAME i of street and numb

FULL NAME Geo W Gillilan

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: White

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Mared

DATE OF BIRTH: Ross Co Ohio, (Month) (Day) (Year)

AGE _____ yrs. _____ mos. _____ ds.

If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE (City or town, State or foreign country)

PARENTS
- NAME OF FATHER
- BIRTHPLACE OF FATHER (City or town, State or foreign country)
- MAIDEN NAME OF MOTHER
- BIRTHPLACE OF MOTHER (City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____, 191__, _____

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____ (Month) _____ (Day), 19 (Y

I HEREBY CERTIFY, that I attended deceased _____, 191__, to _____, 19

that I last saw h_____ alive on _____, 19

and that death occurred, on the date stated above, at _____

The CAUSE OF DEATH* was as follows:

_____

_____

_____

_____ (Duration) _____ yrs. _____ mos. _____

Contributory (SECONDARY) _____

_____ (Duration) _____ yrs. _____ mos. _____

(Signed) _____

_____, 191__ (Address) _____

*State the Disease Causing Death, or, in deaths from Violent Causes, (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENT RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL _____, 19

UNDERTAKER

ADDRESS