

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

7015

PLACE OF DEATH
County Schuyler
Township Prairie
or
Village
or
City (NO. _____ St. _____ Ward _____)

Registration District No. 806 File No. _____
Primary Registration District No. 6051 Registered No. 4

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

FULL NAME Virgie Franklin Gillespie

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Male</u>	COLOR OR RACE <u>white</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>single</u> (Write the word)
DATE OF BIRTH <u>Jan 4, 1915</u> (Month) (Day) (Year)		
AGE <u>1</u> yrs. <u>1</u> mos. <u>15</u> ds. If LESS than 1 day, ___ hrs. or ___ min.?		
OCCUPATION (a) Trade, profession, or particular kind of work <u>none</u> (b) General nature of industry, business, or establishment in which employed (or employer)		
BIRTHPLACE (City or town, State or foreign country) <u>Schuyler Co Mo</u>		
PARENTS	NAME OF FATHER <u>Daniel Richard Gillespie</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Mo</u>	
	MAIDEN NAME OF MOTHER <u>Debra Clark</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Mo</u>	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Feb 18, 1915
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Feb 17, 1915, to Feb 18, 1915, that I last saw him alive on Feb 17, 1915, and that death occurred, on the date stated above, at 7 a.m.

The CAUSE OF DEATH* was as follows:
Cerebraus Pneumonia
108

Contributory (SECONDARY)
None
(Duration) ___ yrs. ___ mos. ___ ds.

(Signed) W.H. Gieber M. D.
Feb 18, 1915 (Address) Queen City

*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 _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed Feb 18, 1915 W.H. Gieber
REGISTRAR

PLACE OF BURIAL OR REMOVAL
Tarr Cem

DATE OF BURIAL
Feb 18, 1915

UNDERTAKER
W.B. Biggs

ADDRESS
Queen City

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.

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
Association]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc. of (name origin; "Cancer" is less definite; avoid

use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

N. B. Every item of information should be carefully analyzed. AGE should be stated EXACTLY. PHYSICIANS should affix their names to every important CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCURRENCE TO BE VERY IMPORTANT.

PLACE OF DEATH

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

County Schuylers
 Township Prospire
 or
 Village _____
 or
 City _____

Registration District No. 806 File No. _____
 Primary Registration District No. 6057 Registered No. H
 (No. _____) (St. _____) (Ward _____)

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

FULL NAME

Virgie Frankie Gillispie

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX M COLOR OF RACE W. SINGLE S. MARRIED W. WIDOWED W. OR DIVORCED W. (Write the word)

DATE OF DEATH _____, 1915
 (Month) _____ (Day) _____ (Year) _____

DATE OF BIRTH _____, 1915
 (Month) _____ (Day) _____ (Year) _____

HEREBY CERTIFY, that I attended deceased from _____, 1915, to _____, 1915, that I last saw h. _____, 1915, and that death occurred, on the date stated above, at _____ m.

AGE _____ yrs. _____ mos. _____ ds. IF LESS than 1 day, _____ hrs. or _____ min.

The CAUSE OF DEATH* was as follows: _____

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) _____

Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds. (Signed) _____ M. D. _____ 1915 (Address) _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Dan Gillispie

*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 _____

(ADDRESS) Queen City, Mo.

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____ 1915

Filed Feb 17 1915 S. W. H. Fisher REGISTRAR

UNDERTAKER _____ ADDRESS _____

Original file, date Feb - 1915 All information called for must be written on this Supplementary Certificate.

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health Association]

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