

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

Do not use this space.

25260

1. PLACE OF DEATH

County St. Charles Registration District No. 757
St. Charles Primary Registration District No. 3036
 City St. Charles (No. County any other) St. _____ Ward _____

File No. _____
 Registered No. 127

2. FULL NAME Rebecca Gillette

(a) Residence No. _____ St. _____ Ward Cottleville Mo
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred 2 yrs. - mos. - da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Unwedded

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Wm P. Gillette

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 27 - 1845

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ____ hrs. or ____ min.
81 | 11 | 14

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) St. Charles County
 (STATE OR COUNTRY) Mo

10. NAME OF FATHER Abraham Hoffmann

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
 (STATE OR COUNTRY) No History

12. MAIDEN NAME OF MOTHER Susan Jameson

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
 (STATE OR COUNTRY) Virginia

14. INFORMANT Geo. A. Gillette
 (Address) Cottleville Mo

15. FILED 8-11 19 27 Geo. Beckmeyer
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 11 19 27

17. I HEREBY CERTIFY, That I attended deceased from Aug 7, 1927, to Aug 11, 1927, that I last saw him alive on Aug 11, 1927, and that death occurred, on the date stated above, at 7 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral Hemorrhage

8:30 P.
7:17 (duration) 10 yrs. - mos. - da.

CONTRIBUTORY (SECONDARY) Arteriosclerosis
 (duration) _____ yrs. _____ mos. _____ da.

18. WHERE WAS DISEASE CONTRACTED Home
 IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH _____ DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS Clinical Symp

(Signed) H. B. Bessing, M. D.
812, 1927 (Address) St. Charles 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 Cottleville Mo. DATE OF BURIAL Aug 14 19 27

20. UNDERTAKER W. Hallmeyer & Sons Co ADDRESS 900 2nd St

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.

