

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

Do not use this space.

36315

File No. \_\_\_\_\_  
Registered No. 66  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**1. PLACE OF DEATH**

County Clinton Registration District No. 204  
Township Shoal Primary Registration District No. 5282  
City \_\_\_\_\_ (No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

**2. FULL NAME** Kate P. Gilmore

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

**PERSONAL AND STATISTICAL PARTICULARS**

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

Female | white | widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov. 25, 1954

| 7. AGE | YEARS     | MONTHS   | DAYS     | IF LESS than 1 day, ..... hrs. or ..... min. |
|--------|-----------|----------|----------|--|
|        | <u>73</u> | <u>1</u> | <u>2</u> |  |

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work at home  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
(c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) Pennsylvania  
(STATE OR COUNTRY)

10. NAME OF FATHER James Gilmore

11. BIRTHPLACE OF FATHER (CITY OR TOWN) not known  
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER not known

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) not known  
(STATE OR COUNTRY)

14. INFORMANT Mrs. Annie Siever  
(Address) St. Joseph Mo.

15. FILED 17 Dec 1927 D. C. N. Risley  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec. 27 1927

17. I HEREBY CERTIFY, That I attended deceased from Dec-15, 1927, to Dec-27, 1927, that I last saw her alive on Dec-26, 1927, and that death occurred, on the date stated above, at 264 A m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Lobar Pneumonia

108 (duration) yrs. mos. 11 da.

CONTRIBUTORY (SECONDARY) 1010 (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED  
IF NOT AT PLACE OF DEATH? \_\_\_\_\_

0 DID AN OPERATION PRECEDE DEATH? No. DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? No.

WHAT TEST CONFIRMED DIAGNOSIS?  
(Signed) H. A. Cox, M. D.

1770, 1927 (Address) Mirabile 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 Evergreen Cemetery DATE OF BURIAL Dec 29 1927

20. UNDERTAKER J. W. Poland ADDRESS Cameron

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

17 1928

