

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

Do not use this space.

37678
11/27

1. PLACE OF DEATH

County Newton Registration District No. 611
 Township 5 mile Primary Registration District No. 6258
 City Near Pacific (No. Pacific Mo RFD#1)

File No. _____
 Registered No. _____
 St. _____ Ward _____

2. FULL NAME

(a) Residence No. _____ St. _____ Ward _____
 (Usual place of abode)
 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.
 (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 29 1925

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	2	2		

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work _____
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Near Pacific Mo
 (STATE OR COUNTRY)

10. NAME OF FATHER Frank Gilstrap

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Near Pacific Mo
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Lotta Davis

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Newburg Mo
 (STATE OR COUNTRY)

14. INFORMANT Frank Gilstrap
 (Address) Pacific Mo.

15. FILED 11 28 1928 C. E. Norris
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12-29 1927

17. I HEREBY CERTIFY, That I attended deceased from Dec 8 - 1927 to Dec 29, 1927 that I last saw her alive on Dec 27, 1927 and that death occurred, on the date stated above, at 3:45 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pneumo-pneumonia
107A

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

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

19. DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

20. WAS THERE AN AUTOPSY? _____
 WHAT TEST CONFIRMED DIAGNOSIS? _____
 (Signed) W. O. Barnard, M. D.
 , 19 _____ (Address) Seneca 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.

21. PLACE OF BURIAL, CREMATION, OR REMOVAL Hornet Cem. DATE OF BURIAL 12-30 27.

22. UNDERTAKER Hurlbird Mfg Co ADDRESS Aspin Mo

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

10029

10029

CAUSE OF DEATH is plain

may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIAN'S RECORD state fully applied. AGS should be stated EXACTLY. PHYSICIAN'S RECORD state

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Newton
Township 5 mile
City (No.) St. Ward

Registration District No. 611
Primary Registration District No. 621-8

File No.
Registered No.
St. Ward

2. FULL NAME

(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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

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

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT (Address)

15. FILED 1/30, 19 1921

C. E. Morris
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12-29 1921

17. I HEREBY CERTIFY That I attended deceased from 19....., and that I last saw him alive on 19....., and that death occurred, on the date stated above, m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Primary Pneumonia

CONTRIBUTORY (SECONDARY)

me (duration) yrs. mos. ds. 30

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATOR PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) M. D.

, 19 (Address)

*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

DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

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

SUPPLEMENTARY

Attention should be careful in plain terms, so that it may be important.

27973-5