

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

Do not use this space.

15058

1. PLACE OF DEATH

County Gasconade Registration District No. 409 File No. 7
 Township Dunneweg Primary Registration District No. 4242 Registered No. _____
 City Dunneweg (No. _____) St. _____ Ward _____

2. FULL NAME

Normeta Lavone Gilliam
 (a) Residence. No. _____ St. _____ Ward _____ (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 Female 4. COLOR OF SKIN White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED child
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) 4 July
 7. AGE YEARS MONTHS DAYS 8 29 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) child
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Dunneweg Mo. (STATE OR COUNTRY)
 10. NAME OF FATHER Preston Gilliam
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) Tennessee (STATE OR COUNTRY)
 12. MAIDEN NAME OF MOTHER Bertha Lee
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Newton County (STATE OR COUNTRY)

14. INFORMANT Mrs. Bertha Gilliam (Address) Dunneweg Mo.
 15. FILED 4-2-29 Doris Clark REGISTRAR
4-15-29 Dr. work add.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 3 1929
 17. I HEREBY CERTIFY, That I attended deceased from 4-18, 1929, to 4-3, 1929, that I last saw him alive on 4-3-29, 1929, and that death occurred, on the date stated above, at _____.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

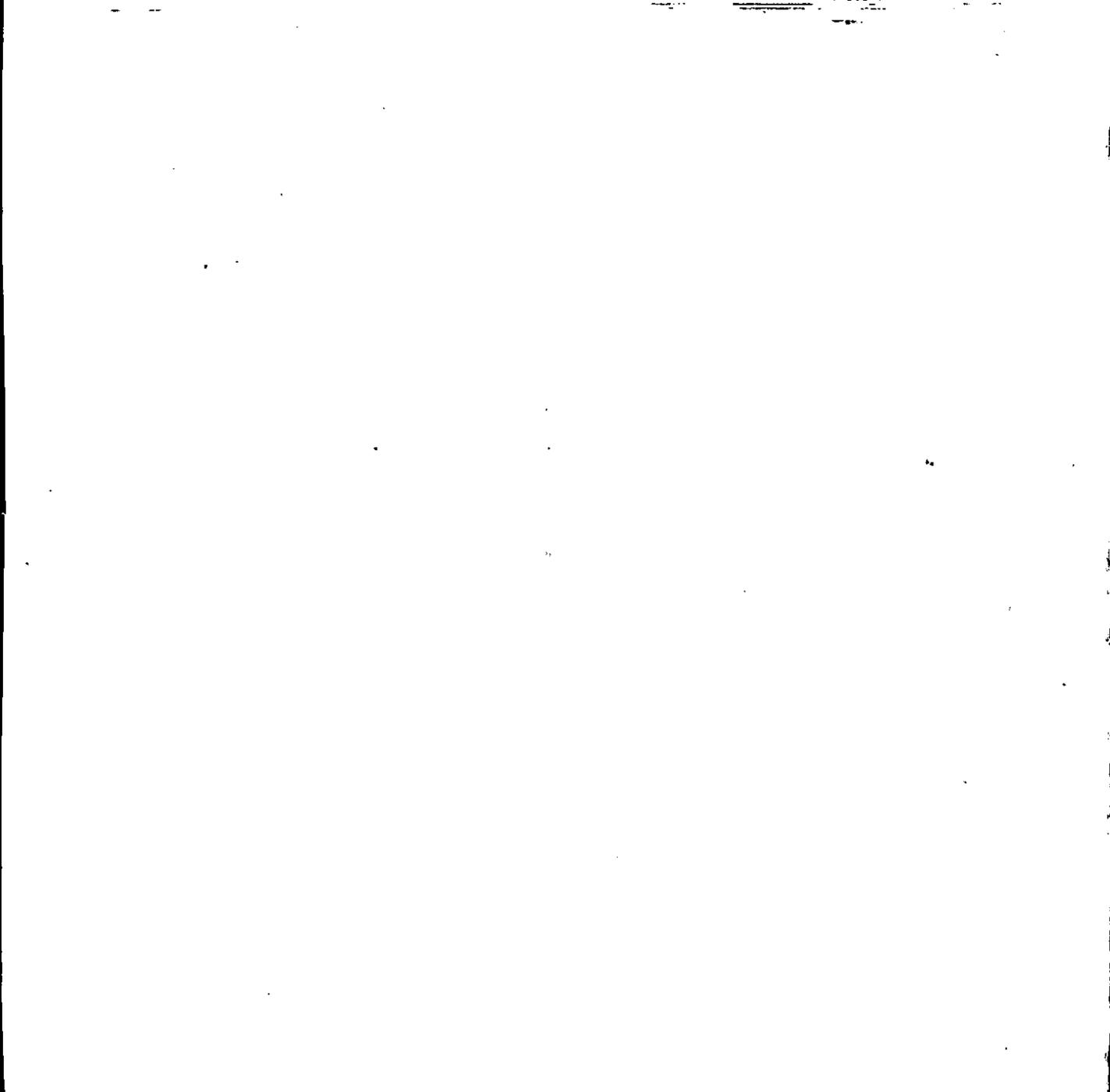
159A Hypertrophied
109A (duration) from birth yrs. mos. ds.
 CONTRIBUTORY Broncho pneumonia (SECONDARY) (duration) _____ yrs. mos. ds. 4

18. WHERE WAS DISEASE CONTRACTED _____ IF NOT AT PLACE OF DEATH _____
 DID AN OPERATION PRECEDE DEATH _____ DATE OF _____
 WAS THERE AN AUTOPSY? ✓
 WHAT TEST CONFIRMED DIAGNOSIS _____ (Signed) Elmer Wood, M.D.
4/15, 1929 (Address) John Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, OF HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Forest Park John DATE OF BURIAL April 5 1929
 20. UNDERTAKER P. M. Clark ADDRESS Galena Kansas

Dr. J. C. ...



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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Gasconade Registration District No. 409 File No. 7
 Township _____ Primary Registration District No. 4242 Registered No. _____
 City Quinn (No. _____ St. _____ Ward _____)

2. FULL NAME

Obnetai Lavone Gilliam
 (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 W (write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 4, 1928

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
8 29

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____ (duration) _____ yrs. _____ mos. _____ ds.
 (b) General nature of industry, business, or establishment in which employed (or employer) _____ (duration) _____ yrs. _____ mos. _____ ds.
 (c) Name of employer _____

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

PARENTS
 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 4/15, 1929 Dr. Wm. E. Keadie REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 3 1929

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____
 DID AN OPERATION 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 _____

Porter Clark, Galena, Kans.

SUPPLEMENTARY

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