

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

Do not use this space.

24 JUL 1929

1. PLACE OF DEATH

County Callaway
Township South
City Portland, Mo (No.)

Registration District No. 105-
Primary Registration District No. 5155-

File No. 17474
Registered No. 14
St. Ward)

2. FULL NAME

Martha Jane Gilman
(a) Residence. No. St., Ward.
(Usual place of abode)

Length of residence in city or town where death occurred 5 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 White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) * Widowed
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF James R. Gilman
6. DATE OF BIRTH (MONTH, DAY AND YEAR) 11
7. AGE YEARS MONTHS DAYS If LESS than 1 day, ... hrs. or ... min.
76 1 5

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

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

10. NAME OF FATHER Beverly Heathen Windley

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

12. MAIDEN NAME OF MOTHER Martha Clanton

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

14. INFORMANT Lelia May Gibson
(Address) Portland Mo

15. FILED July 12 1929 W. H. Williams
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5-12 1929

17. I HEREBY CERTIFY, That I attended deceased from 1925 19 Feb 26 19 29
that I last saw h. l alive on May 12, 19 29 and that death occurred, on the date stated above, at 12:10 P. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Softening of brain

8 hrs (duration) 2 yrs. mos. da.

CONTRIBUTORY (SECONDARY) 8
(duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED 8
IF NOT AT PLACE OF DEATH?

8 DID AN OPERATION PRECEDE DEATH? DATE OF

8 WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS Exp. Microscopic
(Signed) J. H. Granger, M. D.
, 19 (Address) Portland 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 Old Salem Cemetery DATE OF BURIAL 5-14-1929

20. UNDERTAKER W. H. Williams ADDRESS Mokane Mo

LY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every statement 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.

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SECRET

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**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 Callaway

Registration District No. 105-

File No. _____

Township Wurlesburg

Primary Registration District No. 5-15-3-

Registered No. 14

City _____ (No. _____) St. _____ (Ward _____)

2. FULL NAME

Martha Jane Gilman

(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) 4-9-1853

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
<u>46</u>		<u>1</u>	<u>3-</u>	

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 6-12-29 W B Williamson REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5-12 1929

17. I HEREBY CERTIFY That I attended deceased from _____ 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 _____

20. UNDERTAKER _____ ADDRESS _____

SUPPLEMENTARY

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B. --- 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.

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

PLH 615