

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

Do not use this space.

24806

1. PLACE OF DEATH

County Jackson
Township Kennett
City Kennett

Registration District No. 570
Primary Registration District No. 1117

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

2. FULL NAME

Gilkison - James W

(a) Residence. No. 1117 Pearl Street St. 7 Ward. 1
(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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 9 - 1859

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
70 2 15

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Stationary Engineer
(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) St. Louis Missouri

PARENTS

10. NAME OF FATHER Mark Gilkison

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT

(Address) Dr. George F. Gilkison 5256 Shilwood Road Kennett Mo

15. FILED

7/26/29 M. M. Crane REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 25 19 29

17. I HEREBY CERTIFY, That I attended deceased from July 15-29 19 29 to July 25 19 29 that I last saw him alive on July 25 19 29, and that death occurred, on the date stated above, at 5:45 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chr. myocarditis
131
931

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

Chr. nephritis
(duration) 2 yrs. mos. ds.

18. WHERE THE DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH K. C. Mo

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) Henry Schneiderman, M. D.
7/26/29 (Address) 400 Apple

*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

Galvary Cemetery July 27 19 29

20. UNDERTAKER

ADDRESS

John J. Sheehan K.C. 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.

34
1
2
31

