

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

Do not use this space.

6718

1. PLACE OF DEATH

County.....
Township.....
City.....

Registration District No. **791**
Primary Registration District No. **1003**

File No.....
Registered No. **1543**
St. Ward)

2. FULL NAME

(a) Residence. No. **2939 Scott Avenue** Ward. **22**
(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 **Colored** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **Married**

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

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

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
abt	52	—	—	—

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

9. BIRTHPLACE (CITY OR TOWN) **Aberdeen**
(STATE OR COUNTRY) **Mississippi**

10. NAME OF FATHER **Harmon Gilmore**

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

12. MAIDEN NAME OF MOTHER **Ann Unknown**

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

14. INFORMANT **Lillie Gilmore**
(Address) **2939 Scott Ave**

15. FILED **11:15 AM** **Walter Starker**
19..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Feb. 8, 1930**

17. I HEREBY CERTIFY, That I attended deceased from **Jan. 8th** to **Feb. 8th** 19**30** that I last saw him alive on **2/8** 19**30**, and that death occurred, on the date stated above, at **2:13 P. m.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Intestinal Reflexes
131
(duration) **2** yrs. mos. ds.

CONTRIBUTORY (SECONDARY) **Diets**
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTACTED
IF NOT AT PLACE OF DEATH

19. DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) **J. H. McKinney** M. D.

(Address) **3700 Laclede Ave**

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

19. PLACE OF BURIAL, CREMATION, OR REMOVAL **Washington Park** DATE OF BURIAL **Feb 16 1930**

20. UNDERTAKER **Peoples Und Co** ADDRESS **Franklin Ave**

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.

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