

NOV 26 1930

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

Do not use this space.

V 16919-a

1. PLACE OF DEATH

County Ozark
 Township Noble
 City Wasola

Registration District No. 1699
 Primary Registration District No. 6286

File No. 8
 Registered No. 8
 St. _____ Ward _____

2. FULL NAME

Saphrona Gilliland

(a) Residence. No. _____ St. _____ Ward _____
 (Usual place of abode)

Length of residence in city or town where death occurred yrs. 5 mos. 11 ds. 1
 How long in U.S., if of foreign birth? yrs. _____ mos. _____ ds. _____

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Widow

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

John Gilliland

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

Aug 9 - 1870

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, _____ hrs. _____ min.
 or _____ min.

70

1

16

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)

Armo

(STATE OR COUNTRY)

Douglas County Mo.

10. NAME OF FATHER

Samuel Day

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

New York

(STATE OR COUNTRY)

U. S.

12. MAIDEN NAME OF MOTHER

Arrena Day

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

Virginia

(STATE OR COUNTRY)

U. S.

14.

INFORMANT

Arrena & Olga Gilliland
Wasola, Missouri

15.

FILED

Sept 1, 1930

James B. Davis
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

19

17.

I HEREBY CERTIFY, That I attended deceased from

Sept 25, 1928, to Sept 28, 1928

that I last saw her alive on May 8, 1928, and that death occurred, on the date stated above, at 1 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Valvular disease of heart

92.1

(duration) 1 yrs. 8 mos. 13 ds.

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?

no

WHAT TEST CONFIRMED DIAGNOSIS?

Clinical

(Signed)

G. H. Taylor

M. D.

, 19

(Address)

Almartha 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

DATE OF BURIAL

Thornfield

May 11 1930

20. UNDERTAKER

ADDRESS

state blue
state

should be carefully
of the state

STATE
O

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

3-30
ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Guthrie
Township North
City North (No.)

Registration District No. 649
Primary Registration District No. 286

File No.
Registered No.
St. Ward

2. FULL NAME

Saphrona Gilliland

(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) wid

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 Oct 15 1930 Oct 15 1930
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 10 1930

17. I HEREBY CERTIFY, That I attended deceased from 19....., to 19....., that I last saw h. 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

Neighbors Thornfield

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state 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

WHILE FILING. NO UNPAID INK. THIS IS A PERMANENT RECORD

S-169192

11/11/11