

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

Do not use this space.

23543

1. PLACE OF DEATH

County Mason Registration District No. 547 File No. _____
 Township Mason Primary Registration District No. 3927 Registered No. 194
 City Hannibal (No. St. Elizabeth Hospital) St. 6 Ward)

2. FULL NAME

Sarah Jane Gilliland
 (a) Residence. No. _____ St. _____ Ward. Palls Co. Mo.
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Charles Leslie Gilliland</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>April 12-1889</u>		
7. AGE	YEARS <u>51</u>	MONTHS <u>3</u>
	DAYS <u>17</u>	IF LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. at home
 (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) Morgan Co. Ill.

PARENTS	10. NAME OF FATHER <u>Benjamin F. Burns</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <u>don't know</u>
	12. MAIDEN NAME OF MOTHER <u>Mary Ellen May's</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <u>don't know.</u>

14. INFORMANT Charles Leslie Gilliland
 (Address) R. F. D. #1 - New London Mo

15. July 30 1933 G. G. Gause
 REGISTRAR

1 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 29 - 1930
 17. I HEREBY CERTIFY, That I attended deceased from 7-27, 1930 to 7-29, 1930
 that I last saw h. em alive on 7-28, 1930, and that death occurred, on the date stated above, at 3:00 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Nephritis

132A
 (duration) ? unknown yrs. mos. ds.
 CONTRIBUTORY (SECONDARY) unknown
 (duration) _____ yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH. Palls Co

0 DID AN OPERATION PRECEDE DEATH? no DATE OF _____
 WAS THERE AN AUTOPSY? no
 WHAT TEST CONFIRMED DIAGNOSIS Laboratory
 (Signed) J. Hardesty, M. D.
 . 19 33 (Address) Hannibal 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 Mt Olenier Cem. DATE OF BURIAL July 30 1930

20. UNDERTAKER Schwartz Funeral Home ADDRESS Hannibal Mo.

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

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 should be given.

1930

