

OCT 30 1930

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

Do not use this space.

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1. PLACE OF DEATH

County Moniteau Registration District No. 1095
Township _____ Primary Registration District No. 4336
City Coleman (No. _____) St. _____ Ward _____

2. FULL NAME

Lena Mae Gilmore

(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) married

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

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)

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 9-13-1930 G. E. Martin REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from Aug 30, 1930, to Sept 10, 1930 that I last saw her alive on Sept 9, 1930, and that death occurred, on the date stated above, at 1:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Typhoid fever

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) Dr. Bowlin, M. D.

8-12-1930 (Address) Tipton, 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

19

20. UNDERTAKER ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state.

**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 Monteau Registration District No. 1095 File No. _____
 Township Moreau Primary Registration District No. 4336 Registered No. _____
 City Clarksburg (No. _____) St. _____ (Ward) _____

2. FULL NAME Lenoe Mae Gilmore
 (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

MEDICAL CERTIFICATE OF DEATH

3. SEX 4 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 4 - 1904

7. AGE YEARS <u>25</u>	MONTHS <u>10</u>	DAYS <u>5</u>	IF LESS than 1 day, hrs. _____ or min. _____
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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) Cooper Co Mo
 (STATE OR COUNTRY)

10. NAME OF FATHER Robt Harper

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

12. MAIDEN NAME OF MOTHER Alta Bumide

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Cooper Co Mo
 (STATE OR COUNTRY)

14. INFORMANT Marvin Gilmore
 (Address) Clarksburg Mo

15. FILED 9-19-1930 Jennette
 REGISTRAR

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

17. I HEREBY CERTIFY That I attended deceased from Aug. 30 1930 to Sept. 10 1930, and that I last saw h. or alive on Sept. 9 1930, and that death occurred, on the date stated above at 11:30 a. m.

THE CAUSE OF DEATH WAS AS FOLLOWS
Typhoid Fever

18. WHERE WAS DISEASE CONTRACTED _____ (duration) yrs. mos. 20 ds.
 CONTRIBUTORY (SECONDARY) _____
 (duration) yrs. mos. ds.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Mount Pleasant Cem DATE OF BURIAL 9/10 1930

20. UNDERTAKER Walhaver & Freidmeyer, California ADDRESS _____

EXAMINER

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

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.

*State the DISEASE CAUSING DEATH, or if deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

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