SMITH

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

Do not use this space.

38410

1 PLACE OF DEATH

County ADAIR — Registration District No. 4 — File No.

Township — Primary Registration District No. 3001 — Registered No. 183

City KIRKSVILLE MO (No. 406 E RANDOLPH St. Ward)

2. FULL NAME JOHN W GILL

(a) Residence. No. KIRKSVILLE MO 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
MALE	WHITE	MARRIED

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) JULY 28th 1872

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ...min.
58	4	19	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work ENGINER

(b) General nature of industry, business, or establishment in which employed (or employer) STATIONARY

(c) Name of employer TEACHERS COLLEGE

9. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY) ST LOUISMO

PARENTS

10. NAME OF FATHER JOHN W GILL SR

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

12. MAIDEN NAME OF MOTHER MARGRET HARTNET

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

14. INFORMANT Lillie Gill
(Address) KIRKSVILLE MO

15. FILED ..., 19... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 18 1930

17. I HEREBY CERTIFY, That I attended deceased from Dec 18, 1930, to Dec 18, 19..., that I last saw him alive on Dec 18, 1930 and that death occurred, on the date stated above, at 4:45 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral Embolism

823

(duration) ...yrs. ...mos. 0 ds.

CONTRIBUTORY (SECONDARY) 748

(duration) ...yrs. ...mos. ...ds.

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) E. S. Smith, M. D.

12/19, 1930 (Address) Kirksville

*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
MAPLE HILL	12-20 1930

20. UNDERTAKER	ADDRESS
Davis & Wilson	Kirksville

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.

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: Adair — Registration District No.: 4 — File No.:
Township: — Primary Registration District No.: 3001 — Registered No.: 183
City: Kirksville (No. , St. Ward)

2. FULL NAME: John W. Gill

(a) Residence. No. St., Ward. (If nonresident give city or town and State)
(Usual place of abode)
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: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): M

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 COUNTY)

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTY)

14. INFORMANT
(Address)

15. FILED 12-26 19 30 Mrs C H Becker
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 18 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:

(duration) yrs. mos. 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?
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 19

20. UNDERTAKER — ADDRESS

SUPPLEMENTARY

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN CAUSE 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

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