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

8747

1. PLACE OF DEATH
County: Bollinger — Registration District No.: 69 — File No.: 18
Township: Wayne — Primary Registration District No.: 5-108 — Registered No.:
City: (No. ..... St. ..... Ward)

2. FULL NAME: Mary Jane Gilliland

(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.

MAY 21 1931

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write the word*): widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF (OR) WIFE OF: Wilson W. Gilliland

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Oct 8, 1861

7. AGE: Years 69 — Months 5 — Days 8 — 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): Mo

PARENTS
10. NAME OF FATHER: Marion Fullright
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY): Mo
12. MAIDEN NAME OF MOTHER: Mary Mayfield
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY): Mo

14. INFORMANT: Joseph Gilliland
(Address): Gepay Mo

15. FILED: 4-18-1931 — A. T. K. — REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): March 16 1931

17. I HEREBY CERTIFY, That I attended deceased from Jan 1st, 1931, to March 16, 1931, that I last saw h. alive on March 17, 1931, and that death occurred, on the date stated above, at 5.30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
50 E
Rheumatism
(duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (SECONDARY)
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED: at home
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? no DATE OF
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? none
(Signed) A. T. Kirkpatrick, M.D.
, 19 (Address) Zalma 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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Bonney Cemetery — DATE OF BURIAL: March 17 1931
20. UNDERTAKER: Leonard Funeral — ADDRESS: Gepay Mo

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

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (No....., ...St. .....Ward)

2. FULL NAME .....

(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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)

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)

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....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

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. (See reverse side for additional space.)

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.