

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

Do not use this space.

32669

File No. _____
Registered No. 92
St. _____ Ward _____

1. PLACE OF DEATH
49 County Jasper Registration District No. 417
Township _____ Primary Registration District No. 3021
11 City Webb City, Mo.
7. FULL NAME Dolores June Gillum
(a) Residence, No. 12 + Washington 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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 12 - 1931
7. AGE YEARS MONTHS DAYS If LESS than 1 day,hra. ormin.
1 5 12

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Child
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

MOTHER FATHER
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Webb City Missouri
13. NAME Albert Gillum
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Carthage Mo.
15. MAIDEN NAME Madys Ireland
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Webb City Mo.

17. INFORMANT Albert L. Gillum
(ADDRESS) _____
18. BURIAL, CREMATION, OR REMOVAL PLACE Park Cemetery DATE Oct 26 1937
19. UNDERTAKER (ADDRESS) R. M. Stornant Carthage Mo.
20. FILED 10/25 1937 R. M. Stornant Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 24 1937
22. I HEREBY CERTIFY, That I attended deceased from Oct 22 1937 to Oct 24 1937
I last saw her alive on Oct 24 1937 Death is said to have occurred on the date stated above, at 4:15 P.m.
The principal cause of death and related causes of importance were as follows:

Broncho-pneumonia
i. i. u. T. A.
Other contributory causes of importance: ①
Date of onset 10/23/37

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____
(Signed) R. M. Stornant M. D.
(Address) Webb City Mo.

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.

NOV 23 1937

Acid Broncho
Pneumonia
follow measles
or whooping
cough 2. No
accompanied a common cold

**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 Gascon
Township Webb City
City Webb City (No. _____)

Registration District No. 417
Primary Registration District No. 3021

File No. _____
Registered No. 92
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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) S.

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. Trade, profession, or particular kind of work done, as spliner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE _____ DATE _____ 19____

19. UNDERTAKER (ADDRESS)

20. FILED 1/7 33 AM Stormont
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 24 1932

22. I HEREBY CERTIFY, That I attended deceased from _____ to _____, 19____

I last saw him alive on _____, 19____. Death is said to have occurred on the day stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:

Bronchitis pneumonia Date of onset _____

Other contributory causes of importance: 10700

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____

(Signed) _____, M. D.

(Address) _____

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

SUPPLEMENTARY