

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

Do not use this space.

34962

1. PLACE OF DEATH

County Callaway Registration District No. 105

Township Mokane Primary Registration District No. 4064

City Mokane (In Mo.)

File No. _____

Registered No. 38

St. _____ Ward _____

2. FULL NAME

Mitchel Martine Gilman

(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 7 yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Married

6A. IF MARRIED, WIDOWED, OR DIVORCED

HUSBAND OF (OR) WIFE OF

Lucy Virginia Gilman

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

July-9-1957

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

75

4

1

8. OCCUPATION OF DECEASED

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

Farmer

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

Callaway, Co. Mo.

(STATE OR COUNTRY)

10. NAME OF FATHER

Wm Gilman

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

Mo. 11. 31

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

Leticia Callaway

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

Mo. 11.

(STATE OR COUNTRY)

14.

INFORMANT

(Address)

Wm Gilman
Hickman Mo. R.F.D. No. 1

15.

FILED 11-12, 1932

W.H. Williams

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11-10-32 19

17.

I HEREBY CERTIFY, That I attended deceased from

1931, to 11-10-32, 1932
that I last saw him alive on 11-1-32, 1932, and that death occurred, on the date stated above, at 3:40 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Carcinoma of right-eye + side of face + spheno (Ethmoid)

CONTRIBUTORY (SECONDARY)

Coner

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) W.H. Williams, M. D.
, 19 (Address) Mokane 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

River View Cemetery

11-12 1932

20. UNDERTAKER

ADDRESS

Wm McGroove

Mokane Mo

X. 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.

Please state
primary
seat of cancer

no information

**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 Callaway Registration District No. 105- File No. _____
 Township _____ Primary Registration District No. 4064 Registered No. 38
 City Mokane (No. _____) St. _____ Ward _____

2. FULL NAME Mitchell Martin Gilman

(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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED M
(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.
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OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.	11. Total time (years) spent in this occupation
	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)	

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

MOTHER / FATHER 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 19 _____ Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 11-10-32

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

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

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

Carcinoma of right side of face
 Date of onset _____
 Other contributory causes of importance: Cancer

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) _____

SUPPLEMENTARY

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