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.

DEC 23 1937

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

Do not use this space.

File No. 41939

Registered No.

1. PLACE OF DEATH
County: New Madrid — Registration District No.: 274
Township: Lewis — Primary Registration District No.: 6261
City ..... (No. ..... St. ..... Ward)

2. FULL NAME: Gillham

(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: Fem
4. COLOR OR RACE: White
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): Nov 11 - 37

7. AGE — YEARS | MONTHS | DAYS | If LESS than 1 day, ... hrs. or ..... min.

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.
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): Lewis Twp New Madrid Co Mo

FATHER
13. NAME: Burl Scallion
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Sherrell Ark

MOTHER
15. MAIDEN NAME: Collene Hatcher
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Etowah Ark

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL
PLACE: On farm DATE: Nov 11 1937

19. UNDERTAKER (ADDRESS): None

20. FILED: Dec 10, 1937 E. E. Jones, Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): Nov 11, 1937

22. I HEREBY CERTIFY, That I attended deceased from ....., 19....., 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:

	Date of onset
Deformity (Spina Bifida)	

Other contributory causes of importance:

Name of operation: — Date of: —
What test confirmed diagnosis? Deformity 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) E. E. Jones, M. D.
(Address) Kilbourne Mo