

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.

REC'D MAR 13 1939

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

6567
Do not use this space.

1. PLACE OF DEATH *Greene* 2
 (a) County *Greene* Registration District No. *318*
 (b) Township *Springfield* 1 Primary Registration District No. *2001* Registered No. *165*
 (c) City *Springfield* (d) Street No. *857 N. Campbell* St. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.
 2. PRINT FULL NAME *PATSY MARIE GILLUM.*
 (a) Residence, No. *857 N. Campbell* St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED *Single*
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Feb 22-1939*
 7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
0 0 1
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *Infant*
 9. Industry or business in which work was done, as saw mill, bank, etc. *at home*
 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) *Springfield Mo.*
 FATHER 13. NAME *W. Everett Gillum*
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Mo.*
 MOTHER 15. MAIDEN NAME *Mary E. Jindler*
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Mo.*
 17. INFORMANT (ADDRESS) *W. Everett Gillum Springfield, Mo.*
 18. BURIAL, CREMATION, OR REMOVAL PLACE *Oak Lawn* DATE *Feb 24 1939*
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) *W. Klingner Springfield, Mo.*
 20. FILED *Feb 23 1939* *Chas. A. George* Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Feb 23 1939*
 22. I HEREBY CERTIFY, That I attended deceased from *one day only* 19....., 19.....
 I last saw her alive on *2-22-39 5:00 PM*. Death is said to have occurred on the date stated above, at *5:00 A.M.*
 The principal cause of death and related causes of importance were as follows:
Asphyxia lincida
161A
 Date of onset _____
 Other contributory causes of importance:
Born practically dead. Worked for one hour to resuscitate. Probably aspirated fluid before birth.
 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 *Barrett's legs*, M. D.
 (Signed) _____ (Address) *Springfield, Mo.*

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, ^{not} _____

or by _____

Registered Apprentice No. _____, working under my personal supervision.

Signed _____

Licensed Embalmer No. 3358

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.