

REC'D SEP 7 1939

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

28898

Do not use this space.

## 1. PLACE OF DEATH

(a) County Clay Registration District No. 203  
(b) Township Platte Primary Registration District No. 4122 Registered No. 25-  
(c) City Smithville (d) Street No. \_\_\_\_\_ 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 Lourinda LaForce Gillaspay

(a) Residence, No. Smithville, Missouri St.  (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Widowed</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (OR) WIFE OF <u>O &amp; Gillaspay</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>May 25, 1859</u>		
7. AGE YEARS <u>80</u>	MONTHS <u>3</u>	DAYS <u>3</u> IF LESS than 1 day, ..... hrs. or ..... min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>School Teacher</u>	
	9. Industry or business in which work was done, as saw mill, bank, etc. <u>(Retired 1935)</u>	
	10. Date deceased last worked at this occupation (month and year) .....	11. Total time (years) spent in this occupation .....
12. BIRTHPLACE (CITY OR TOWN) <u>Columbia</u> <u>0</u> (STATE OR COUNTRY) <u>Missouri</u>		
FATHER	13. NAME <u>Thomas Kelly Wright</u> <u>1</u>	
	14. BIRTHPLACE (CITY OR TOWN) <u>Virginia</u> <u>1</u> (STATE OR COUNTRY)	
MOTHER	15. MAIDEN NAME <u>Sally Ann Howe</u>	
	16. BIRTHPLACE (CITY OR TOWN) <u>Virginia</u> (STATE OR COUNTRY)	
17. INFORMANT <u>Walter LaForce</u> (ADDRESS) <u>Smithville, Missouri</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Centralia, Mo.</u> DATE <u>August 31, 1939</u>		
19. FUNERAL DIRECTOR <u>McComas Mortuary</u> (ADDRESS) <u>Smithville, Missouri</u>		
20. FILED <u>8-30</u> , 1939 <u>E. C. Hill</u> Local Registrar.		

## MEDICAL CERTIFICATE OF DEATH 1939

21. DATE OF DEATH (MONTH, DAY, AND YEAR) August 28, 1929

22. I HEREBY CERTIFY, That I attended deceased from Feb. 24 - 29 Aug 28, 1927 to Aug 28, 1929  
I last saw her alive on Aug 28, 1929. Death is said to have occurred on the date stated above, at 8 m.  
The principal cause of death and related causes of importance were as follows:  
Arterio Myocarditis  
ASC

Other contributory causes of importance:  
general dropy

Name of operation Tapping abdomen Date of Aug 28  
What test confirmed diagnosis By physician Where an autopsy? no.

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? no.  
If so, specify \_\_\_\_\_  
(Signed) E. C. Hill M. D.  
1929 (Address) Smithville, Mo.

RECEIVED  
District Health Officer No. 8,  
District File Number  
Date Filed 4/15/39

STATEMENT BY LICENSED EMBALMER

I, \*\*\*\*\* Owen J. Bogress, Jr. \*\*\*\*\*, Licensed Embalmer No.\*\*\* 3940\*\*\*

hereby certify that the body recorded on the reverse side of this certificate was embalmed by \*\*\*\*\* MF \*\*\*\*\*

\*\*\*\*\* L. E. \*\*\*\*\*

No. \*\*\*\*\* or by \*\*\*\*\* Registered Apprentice No. \*\*\*\*\*

working under my personal supervision.

Signed *Owen J. Bogress, Jr.*  
Licensed Embalmer No. 3940

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.)