

RECD SEP 19 1938

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

Do not use this space.

29824

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1. PLACE OF DEATH
County Madaway Registration District No. 425
Township St. Francis Hospital Primary Registration District No. 3031
City Marysville (No. St. Francis Hospital) St. _____ Ward _____

445
2. FULL NAME Doza Belle Gilleland
(a) Residence, No. Bedford Square 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. 3 How long in U. S., if of foreign birth? yrs. _____ mos. _____ ds.

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>married</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>C. W. Gilleland</u>				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Dec 12 1880</u>				
7. AGE	YEARS <u>58</u>	MONTHS <u>8</u>	DAYS <u>15</u>	IF LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>Housewife</u>			
	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				1. _____
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Salem Ohio</u>				
FATHER	13. NAME <u>Reuben Johnson</u>			
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Ohio</u>			
MOTHER	15. MAIDEN NAME <u>Elizabeth J. Webb</u>			
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Ohio</u>			
17. INFORMANT <u>C. W. Gilleland Bedford</u>				
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Bedford Sq</u> DATE <u>Aug 27</u> 19 <u>38</u>				
19. UNDERTAKER <u>Floyd Shuck</u> (ADDRESS) <u>Bedford Square</u>				
20. FILED <u>Aug 28</u> 19 <u>38</u> <u>Mamie E. Clardy</u> Registrar				

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 27 1938

22. I HEREBY CERTIFY, That I attended deceased from Aug 23 1938 to Aug 27 1938
I last saw per alive on Aug 27 1938. Death is said to have occurred on the date stated above, at 4 P m.
The principal cause of death and related causes of importance were as follows:
Hemiplegia with right sided paralysis
Date of onset _____

Other contributory causes of importance: _____

Name of operation _____ Date of _____
What test confirmed diagnosis? clinical Was there 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. _____

24. Was disease or injury in any way related to occupation of deceased?
If so, specify _____
(Signed) H. M. Halls Jr, M. D.
556 (Address) Maryville Mo

822

RECEIVED

Office No. 11,

939-1209

SEP 14 1939

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

29824
Do not use this space.

1. PLACE OF DEATH

(a) County Hodaway Registration District No. 625-
(b) Township..... Primary Registration District No. 3031 Registered No.....
(c) City Maryville (d) Street No..... (If death occurred in Hospital or Institution, write its name instead of street and number) St.
(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 Dora Belle Hillland

(a) Residence, No. 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 F 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.
38 8 15

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as 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)

FATHER 13. NAME

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

MOTHER 15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 19

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8-27 1939

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:

Westphal plegia with right sided paralysis
Cerebral hemorrhage
Other contributory causes of importance:
82'

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) Wm Wallace Jr, M. D.

(Address) Maryville

SUPPLEMENTARY

