

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

K. 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.

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

**6058**  
Do not use this space.

1. PLACE OF DEATH 2

(a) County Buchanan Registration District No. 83

(b) Township Crawford Primary Registration District No. 5124

(c) City \_\_\_\_\_ (d) Street No. \_\_\_\_\_ 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 Milton M. Gilmore

(a) Residence, No. Facutt, Mo. St.  (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mrs Octav Gilmore

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb 22, 1880

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, .....hrs. or .....min.
59	11	23	

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. farmer

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) Buchanan County Missouri (STATE OR COUNTRY)

FATHER

13. NAME James Gilmore

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

MOTHER

15. MAIDEN NAME Margret Cogdill

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

17. INFORMANT Mrs. Octav Gilmore (ADDRESS) Facutt, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Facutt Cemetery DATE Feb 1940

19. FUNERAL DIRECTOR (NAME) W. H. Sullivan (ADDRESS) Facutt, Mo.

20. FILED 2/14 1940 W. H. Sullivan Local Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) February 15, 1940

22. I HEREBY CERTIFY, That I attended deceased from Feb 15 1940, to \_\_\_\_\_, 19\_\_\_\_

I last saw h. ~~deceased~~ 2/14 1940 Death is said to have occurred on the date stated above, at 9:00 A.M.

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

Date of onset

Chronic Myocarditis ?

Other contributory causes of importance: None

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? Yes

If so, specify \_\_\_\_\_

(Signed) Dr. Clepton Smith M. D.

(Address) 220 N. 7th St. Facutt, Mo.

RECEIVED  
District Health Officer No. 11,  
District File Number 3412-317  
Date Filed MAR 12 1940

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, or by \_\_\_\_\_  
\_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_  
working under my personal supervision.

Signed W. A. Sullivan  
Licensed Embalmer No. 1738  
P. O. Address Genoa, Mo.

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.