FILED MAY 8 1940

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

15261
Do not use this space.

1. PLACE OF DEATH
(a) County Johnson 2 Registration District No. 426
(b) Township Chilhowee 0 Primary Registration District No. 5581 Registered No. 6
(c) City Chilhowee (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 29 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 3(1) Gilbert White
(a) Residence, No. Chilhowee Mo St. ☐
(Usual place of abode, if no street address, write county or city) (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) Widow
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Sophronia White
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 6-30-1857
7. AGE Years 83 Months 9 Days 13 If LESS than 1 day, ... hrs. or ..... min.

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 Life

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) White Co Tenn

FATHER
13. NAME Martin White
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

MOTHER
15. MAIDEN NAME Sophronia Button
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky

17. INFORMANT (ADDRESS) J. H. White Chilhowee Mo
18. BURIAL, CREMATION, OR REMOVAL
PLACE Burial DATE Apr 14 1940
19. FUNERAL DIRECTOR (NAME) (ADDRESS) Fred Wilkinson Clinton Mo
20. FILED 4/14 1940 O. E. Cook Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Apr-13 1940
22. I HEREBY CERTIFY, That I attended deceased from March 1939 to April 12th 1940
I last saw him alive on April 11th 1940. Death is said to have occurred on the date stated above, at 2:20A m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Cerebral Hemorrhage	4/8-40
94 B	

Other contributory causes of importance:
Arterio Sclerosis and Coronary Sclerosis — years duration

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? No
If so, specify .....
(Signed) G. M. Kendall, M. D.
86 (Address) Chilhowee Mo

(Licensed Embalmer's Statement on Reverse Side)

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

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should sta
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very importan

I X14028

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 Fred Wilkinson

Licensed Embalmer No. 2474

P. O. Address Chicago Ill

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.

No. 2B
2-21-40
1 X22659

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 15·261

Registration District No. 426 Primary Registration District No. 5381 Registrar's No. 6

1. PLACE OF DEATH:
(a) County: Johnson
(b) ~~City or town~~ Chilhowee
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town
(If outside city or town limits write "RURAL")
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Gilbert White
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex M
5. Color or race Black
6. (a) Single, widowed, married, divorced W
6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive years
7. Birth date of deceased 6 – 30 – 1857 (Month) (Day) (Year)
8. AGE: Years 82 ~~80~~ Months 9 Days 13 If less than one day hr. min.
9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) 6/7/40 (Date received local registrar) (b) O. L. Cook (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr day 13 year 1940 hour minute M.
21. I hereby certify that I attended the deceased from , 19, to , 19; that I last saw h alive on , 19; and that death occurred on the date and hour stated above.

Immediate cause of death — Duration
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work? (Specify type of place) (e) Means of injury

23. Signature G. W. Kendall (M. D. or other)
Address Chilhowee Mo. Date signed

SUPPLEMENTARY