

1940 JUL 28 1940

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

22975
Do not use this space.

1. PLACE OF DEATH
(a) County Stoddard 3 Registration District No. 837
(b) Township Castor Primary Registration District No. 6099 Registered No. _____
(c) City Bloomfield, Mo. (d) Street No. Co Home _____ 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 William C. Gill
(a) Residence, No. Stoddard Co mo Rural _____
(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 <u>M.</u>	4. COLOR OR RACE <u>W.</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Divorced</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF _____ (OR) WIFE OF <u>Tillie Gill</u>				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Mar. 13, 1870</u>				
7. AGE	YEARS <u>70</u>	MONTHS <u>2</u>	DAYS <u>29</u>	If LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>Farmer</u>			
	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) <u>Illinois.</u>				
FATHER	13. NAME <u>William Gill</u>			
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Tennessee</u>			
MOTHER	15. MAIDEN NAME <u>Ellen Smyth</u>			
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Tennessee.</u>			
17. INFORMANT <u>Mrs. G. W. Lewis</u> (ADDRESS) <u>Bloomfield, Mo. #Route</u>				
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Bloomfield cem.</u> DATE <u>June 13, 1940</u>				
19. FUNERAL DIRECTOR (NAME) <u>Chiles Und. Co.</u> (ADDRESS) <u>Bloomfield, Missouri.</u>				
20. FILED _____ 19 _____ Local Registrar.				

MEDICAL CERTIFICATE OF DEATH	
21. DATE OF DEATH (MONTH, DAY, AND YEAR)	<u>June 12, 1940</u>
22. I HEREBY CERTIFY, That I attended deceased from <u>May 29</u> to <u>June 12</u> , 19 <u>40</u> I last saw him alive on <u>June 11, 1940</u> Death is said to have occurred on the date stated above, at <u>9:30 A.M.</u> The principal cause of death and related causes of importance were as follows: <u>Paresis</u> <u>acute</u> <u>5/28/40</u>	
Other contributory causes of importance <u>No blood test made</u>	
Name of operation _____	Date of _____
What test confirmed diagnosis? _____	Was there an autopsy? <u>No</u>
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? <u>No</u> If so, specify _____ (Signed) <u>John W. Brown</u> M. D. <u>Bloomfield, Mo.</u> (Address) <u>805</u>	

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 CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very imp

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RECEIVED

District Health Officer No. 2

District File Number 740-120

Date Filed 7/8/40

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 *Irvin S. Cooper*.....

Licensed Embalmer No. 4119.....

P. O. Address Bloomfield, 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **22975-**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **837**

Primary Registration District No. **6099**

Registrar's No.

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

1. PLACE OF DEATH:

(a) County **Stoddard**
(b) City or town **Castor**
(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
In this community (Specify whether years, months or days)

3. (a) PRINT FULL NAME

Wm C. Gill

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex **M**

5. Color or race **W**

6. (a) Single, widowed, married, divorced **Dev**

6. (b) Name of husband or wife

6. (c) Age of husband, or wife, if alive

7. Birth date of deceased

(Month)

(Day)

(Year)

8. AGE:

Years **70**

Months **2**

Days **29**

If less than one day hr. min.

9. Birthplace

(City, town, or county)

(State or foreign country)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

(City, town, or county)

(State or foreign country)

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) (Date received local registrar)

(b) (Registrar's signature)

Loonie PUNCH

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Stoddard**
(c) City or town **Rural**
(If outside city or town limits write "RURAL")
(d) Street No. **County Home**
(If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

20. MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **12**
year **1940** hour minute M.

21. I hereby certify that I attended the deceased from
19 to 19
and that death occurred on the date and hour stated above.
Immediate cause of death

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

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 **John Wilson** (M. D. or other)
Address **Bloomfield**

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **22975**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **837**

Primary Registration District No. **6099**

Registrar's No.

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

1. PLACE OF DEATH

(a) County **Stoddard**
(b) City or town **Easton**
(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
In this community (Specify whether years, months or days)

3. (a) PRINT FULL NAME

Wm C. Gill

3. (b) If veteran, name war. 3. (c) Social Security No.

4. Sex **m** 5. Color or race **w** 6. (a) Single, widowed, married, divorced **ow**

6. (b) Name of husband or wife. 6. (c) Age of husband or wife, if alive. years

7. Birth date of deceased. (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
70 2 29 hr. min.

9. Birthplace. (City, town, or county) (State or foreign country)

10. Usual occupation.

11. Industry or business.

MOTHER FATHER

12. Name

13. Birthplace. (City, town, or county) (State or foreign country)

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) (Date received local registrar) (b) (Registrar's signature)

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.

MEDICAL CERTIFICATION

20. DATE OF DEATH. Month **6** day **12** year **1940** hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19 that I last saw him alive on and that death occurred on the date and hour stated above

Immediate cause of death **Paresis**
acute nephritic
due to
of
due to
Other conditions
made

Duration

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 **John Wilson** (M. D. or other)

Address **Bloomfield Mo** Date signed

SUPPLEMENTARY