

N. 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.

Registration District No. 39 ^{NOV 12 1940}

Primary Registration District No. 4023

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Barton

(b) City or town Golden City, Mo.

(c) Name of hospital or institution: _____
(If outside city or town limits, write "RURAL" and name of township)

(d) Length of stay: In hospital or institution _____
(Specify whether _____)

In this community Three years
years, months or days

3. (a) PRINT FULL NAME Nora Liza Gilliland

8. (b) If veteran, name war _____

8. (c) Social Security No. _____

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife Wife

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

7. Birth date of deceased July 13, 1873
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	66	3	8	hr. min.

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

10. Usual occupation House keeping

11. Industry or business _____

MOTHER FATHER

12. Name Augusta Smith

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

14. Maiden name Elizabeth Hicks
(City, town, or county) (State or foreign country)

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

16. (a) Informant's own signature Elizabeth Hull

(b) Address Greenfield, Mo.

17. (a) Burialfield Cem. (b) Date thereof Oct. 20, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenfield Cem.

18. (a) Signature of funeral director J. W. Ward

(b) Address Greenfield, Mo.

19. (a) Oct 20/40 (b) Wm. Margaret S. Jny
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Barton

(c) City or town Golden City, Mo.
(If outside city or town limits, write "RURAL")

(d) Street No. Depot St.
(If rural, give location)

(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. 20 day
year 1940 hour 11: 20 minutes PM

21. I hereby certify that I attended the deceased from July 18, 1940, to Oct 20, 1940;
that I last saw her alive on Oct 19, 1940;
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Intestinal Nephritis
Due to asarventil with Arterio-Scler
osis

Duration at least one year

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? 39
Specify type of place _____
While at work? _____ (e) Means of injury _____

23. Signature Wm. Brooks (M. D. or other) 1
Address Barton City Mo. Date signed 10-30-40

RECEIVED

District Health Officer No. 6,

District File Number 1140-2787

Date Filed NOV 4 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 J. W. Ward

Licensed Embalmer No. 2832

P. O. Address Greenfield, Mass.

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.