

NOV 20 1940

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 35490

Registration District No. 398

Primary Registration District No. 3019

Registrar's No. 256

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Independence  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
702 W South Ave  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 2  
(Specify whether  
In this community \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME William Harrison Gilley

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

4. Sex Male 5. Color or race Wht 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Bessie Kelly 6. (c) Age of husband or wife if alive 79 years  
7. Birth date of deceased Sept 21 1861  
(Month) (Day) (Year)

8. AGE: Years 79 Months 0 Days 26 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Retired

11. Industry or business \_\_\_\_\_  
12. Name Wiles Jefferson Kelley  
13. Birthplace unknown  
(City or county) (State or foreign country)  
14. Maiden name Mary Ann Fortner  
15. Birthplace unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Emma Davidson  
(b) Address 702 W South Ave

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 30-40  
(Month) (Day) (Year)  
(c) Place: burial or cremation New Garden Cem.

18. (a) Signature of funeral director Cato & Speaks  
(b) Address Independence Mo

19. (a) Oct 18 40 (Date received local registrar) (b) F. L. Cook (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
(c) City or town Independence  
(If outside city or town limits, write "RURAL")  
(d) Street No. 702 W South Ave  
(If rural, give location)  
(e) If foreign born, how long in U. S. A? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 17  
year 1940 hour 4:24 minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from Oct 13-40  
\_\_\_\_\_ 19\_\_\_\_ to Oct 17 1940  
that I last saw him alive on Oct 16 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Somnolence  
Myocarditis  
Nephritis Arteriosclerosis  
Due to \_\_\_\_\_

Duration  
Sept 21  
11 7

Other conditions (Include pregnancy within 3 months of death)  
Due to \_\_\_\_\_  
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 George M. Cook (M. D. or other) \_\_\_\_\_  
Address 11033 Winder Rd Date signed 10/18/40

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

11-10-39  
5-17-39  
I X21492

HEB  
on his own

Son James T. Speck 1715  
William Tiedy Oakland, Cal.  
Granddaughter - Mrs. Wilma Davidson  
me 9/9

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

Signed Roland R. Speck  
Licensed Embalmer No. 3604

P. O. Address Independence, 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. **35490**  
Registrar's No. **267**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
Registration District No. **398**

Primary Registration District No. **3019**

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

1. PLACE OF DEATH:  
(a) County **Jackson**  
(b) City or town **Independence**  
(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)

2. USUAL RESIDENCE OF DECEASED:  
(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_  
(d) Street No. \_\_\_\_\_  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

3. (a) PRINT FULL NAME **Wm Harrison Miller**  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

20. DATE OF DEATH: Month **Oct** day **17** year **1970** hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_; that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour above given.

4. Sex **m** 5. Color or race **w** 6. (a) Single, widowed, married, divorced **wid**  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ year  
7. Birth date of deceased: (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year) \_\_\_\_\_

Immediate cause of death **Renal**  
Due to **Myocarditis Nephritis ascites Chronic**  
Other conditions (include pregnancy within 3 months of death) **12/1**

8. AGE: Years **79** Months **0** Days **26** If less than one day \_\_\_\_\_ h. \_\_\_\_\_ 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) \_\_\_\_\_ (b) Date thereof: (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year) \_\_\_\_\_  
(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

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? \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

23. Signature **George M. Falk** (M. D. or other) \_\_\_\_\_  
Address **1107 W. 11th St. Independence, Mo.** Date signed **12-17-70**

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

SUPPLEMENTAL

