

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **1723**

Registration District No. **73** Primary Registration District No. **3006** Registrar's No. **7**

1. PLACE OF DEATH:
(a) County **Boone**
(b) City or town **Columbia**
(c) Name of hospital or institution **Allie's Chapel (Nine days)**
(d) Length of stay: In hospital or institution **Nine days**
In this community **Nine days**

3. (a) PRINT FULL NAME **George D. Gilmore, Sr.**
(b) If veteran name war **✓**
(c) Social Security No. **✓**

4. Sex **Male** 5. Color or race **W.** 6. (a) Single, widowed, married, divorced **Married**
(b) Name of husband or wife **Dolley Gilmore** 6. (c) Age of husband or wife if alive **62** years
7. Birth date of deceased **May 5th 1876**

8. AGE: Years **65** Months **8** Days **6** If less than one day hr. min.

9. Birthplace **Greenfield Missouri**

10. Usual occupation **Farmer**

11. Industry or business **✓**

MOTHER FATHER
12. Name **Georgette Gilmore**
13. Birthplace **Pennsylvania**
14. Maiden name **Elizabeth Miller**
15. Birthplace **Greenfield Mo**

16. (a) Informant **Dr. Carlen**
(b) Address **900 E. 30th KC Mo**

17. (a) **Carthage Mo** (b) Date thereof **Jan 13, 1941**
(c) Place: burial or cremation **Carthage Mo**

18. (a) Signature of funeral director **Tarkenton (W.H.)**
(b) Address **Columbia Mo**

19. (a) **1/13/40** (b) **Allie Selby**

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Boone**
(c) City or town **Carthage**
(d) Street No. **515 E. Highland**
(e) If foreign born, how long in U. S. A. years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **1** day **11th**
year **1941** hour **6** minute **P.** M.
21. I hereby certify that I attended the deceased from **1941** to **1941**
that I last saw him **alive on** **1941**
and that death occurred on the date and hour stated above.

Immediate cause of death **Heart ailment**
Due to **Cancer Typ II**

Due to _____
Other conditions (include pregnancy within 3 months of death) _____

Major findings: Of operations _____
Of autopsy _____

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? _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? **14**

While at work? _____ (Specify type of place)
(e) Means of injury _____
23. Signature **Marion McEwan** **Coroner**
Address **Columbia Mo** Date signed **1/13/41**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

10
29
4

528

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.....

Licensed Embalmer No.....

P. O. Address.....

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, fact should be so stated above.

No. 2B
2-21-40
22859

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 17237

Registration District No. 73

Primary Registration District No. 3006

Registrar's No.

1. PLACE OF DEATH:

(a) County Boone
(b) City or town Columbu
(c) Name of hospital or institution:
Ellis Trachel
(d) Length of stay: In hospital or institution.....
In this community.....
years, months or days

3. (a) PRINT FULL NAME Geo. D. Gilmore Sr

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 w

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 65 Months 8 Days 6 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) (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)

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.

20. DATE OF DEATH..... Month..... day..... year..... 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 Heart ailment Duration

Due to Cancer type

Due to Carcinoma of lip, lower

Other conditions..... (Include pregnancy within 3 months of death)

Major findings: Of operations.....

Of autopsy.....

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 Eugene M. Briskopf (M. D. or other)

Address Ellis Trachel Cancer Hosp Date signed 3-14-41

SUPPLEMENTAL

MEDICAL CERTIFICATION

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

S-1723