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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. 21420

Registration District No. FILED JUL 11 1941 1948

Primary Registration District No. 3011

Registrar's No. 83

1. PLACE OF DEATH:

(a) County Clay

(b) City or town Excelsior Springs, Missouri.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Veterans Administration
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 11 days (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Daviess 31

(c) City or town Gallatin 1
(If outside city or town limits, write "RURAL")

(d) Street No. -- 0
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)
If yes, name country 1

3. (a) PRINT FULL NAME GILLIHAN, Ben H.

3. (b) If veteran, name war World War

3. (c) Social Security No. No. None.

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife --

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

7. Birth date of deceased September 16, 1886 (Month) (Day) (Year)

8. AGE: Years 54 Months 9 Days 2 If less than one day hr. min.

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

10. Usual occupation Clerk

11. Industry or business Law

FATHER
12. Name William Gillihan
13. Birthplace unknown (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Mary Brousius
15. Birthplace Hagerstown, Maryland (City, town, or county) (State or foreign country)

16. (a) Informant Hospital records
(b) Address Vet. Adm., Excelsior Springs, Mo.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 6-19-40 (Month) (Day) (Year)
(c) Place: burial or cremation Gallatin, Mo.

18. (a) Signature of funeral director Clayde Prichard
(b) Address Excelsior Springs, Mo.

19. (a) June 20-1941 (Date received local registrar) (b) Mrs Ra McCracken (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 18 year 1941 hour 9:15 P.M. minute M.

21. I hereby certify that I attended the deceased from June 7, 1941, 19 to June 18, 1941 that I last saw him alive on June 18, 1941 and that death occurred on the date and hour stated above.

Immediate cause of death — Duration
Pulmonary tuberculosis, bilateral, far advanced active with cavitation — unknown

Due to

Due to

Other conditions Bronchiectasis, Toxic
(Include pregnancy within 3 months of death)
Psychosis

Major findings:
Of operations

Of autopsy None.

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

23. Signature E. A. WELCH, M. D. (M. D. or other)
Address Veterans Administration, Excelsior Springs, Mo. Date signed

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED -
District Health Officer No. 8,
District File Number 7-9-41
Date Filed

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 Robert Ray

Licensed Embalmer No. 4182

P. O. Address Excelsior Spgs., Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.