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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED MAY 2 1942

Registration District No. _____

Primary Registration District No. 4229

Registrar's No. 6

1. PLACE OF DEATH:

(a) County IRON
(b) City or town DES ARC
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
DES ARC Mo
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County IRON
(c) City or town DES ARC Mo
(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.? 0 years.

3. (a) PRINT FULL NAMES JAMES GILKISPIE

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

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 MARCH 21 1967
(Month) (Day) (Year)

8. AGE: Years 75 Months 0 Days 12 If less than one day _____ hr. _____ min.

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

10. Usual occupation TIMBER WORK.

11. Industry or business _____

MOTHER FATHER { 12. Name LEWIS GILKISPIE
13. Birthplace UNKNOWN TENN.
(City, town, or county) (State or foreign country)
14. Maiden name JOHN SON
15. Birthplace UNKNOWN TENN.
(City, town, or county) (State or foreign country)

16. (a) Informant MRS ALICE JOHNSON

(b) Address DES ARC Mo.

17. (a) BURIAL (b) Date thereof 4-3-42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation DES ARC Mo

18. (a) Signature of funeral director See J. Lumber

(b) Address Operton Mo

19. (a) 5-4-42 (b) Virginia R. Miller
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 20
year 1942 hour 11 minute 0 M.

21. I hereby certify that I attended the deceased from 3-30, 1942 to 4-2-1942

that I last saw him alive on 3-25-1942 and that death occurred on the date and hour stated above.

Immediate cause of death Nephritis Duration ✓
Acute Indurative ✓

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy Name

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 J. C. Piles (M. D. or other) MD

Address Indiantown Mo Date signed 4-5-42

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

7
0
0

RECEIVED

District Health Officer No. 4
District File Number 542-63
Date Filed 5-14-42

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 _____

4/2/42, Registered Apprentice No. _____,
working under my personal supervision.

Signed Lee P. Lumbell

Licensed Embalmer No. 3475

P. O. Address Quinton, 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. 14484

Registration District No. 390

Primary Registration District No. 4229

Registrar's No.

1. PLACE OF DEATH:

(a) County Iron

(b) City or town Des Arc

(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 _____
years, months or days

3. (a) PRINT FULL NAME James Gillispie

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 s

6. (b) Name of husband or wife _____

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

7. Birth date of deceased Mar 20 1866
(Month) (Day) (Year)

8. AGE: Years 75 Months _____ Days _____
If less than one day _____ 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 _____
(Burial, cremation, or removal) (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) Citizen of foreign country? _____ (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr Day 10 Year 1942 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to Septicemia Pneumonia

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? _____
(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 _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

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

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

