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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 13 1943

MISSOURI STATE BOARD OF HEALTH

# STANDARD CERTIFICATE OF DEATH

41109

State File No. 41109

Registration District No. 1205 Primary Registration District No. 4253 Registrar's No. 8

**1. PLACE OF DEATH:**

(a) County Johnson

(b) City or town Chilhowie
(If outside city or town limits, write "RURAL" and name of township)

(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
(Specify whether years, months or days)
In this community 35 years approx.

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Mo (b) County Johnson

(c) City or town Chilhowie
(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.

3. (a) PRINT FULL NAME Robert Gilmore

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

4. Sex Male

5. Color or race Colored

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

6. (b) Name of husband or wife Mary Gilmore

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

7. Birth date of deceased 1864 (Month) unknown (Day) (Year)

8. AGE: Years 78 Months unknown Days If less than one day hr. min.

9. Birthplace Henry Co. Mo. (City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business

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

MOTHER
14. Maiden name unknown
15. Birthplace unknown (City, town, or county) (State or foreign country)

16. (a) Informant Ellis Shockly
(b) Address Chilhowie, Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director J. W. Cook
(b) Address Chilhowie Mo

19. (a) 12-9-42 (Date received local registrar) (b) Mrs O. L. Lively (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Dec day 9 year 1942 hour 12 minute 05 P.M.

21. I hereby certify that I attended the deceased from Nov 30, 1942 to Dec 8, 1942; that I last saw him alive on Dec 8, 1942 and that death occurred on the date and hour stated above.

| Immediate cause of death | Duration |
|---|---|
| Angina Pectoris | |
| Heart failure | 10 yrs. |
| Due to Angina Pectoris | |
| 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? (Specify type of place)
While at work? (e) Means of injury

23. Signature E. N. Robinson (M. D. or other) D.O.
Address Chilhowie Mo Date signed Dec 9, 1942

(Licensed Embalmer's Statement on Reverse Side)

CEIVED

District Health Officer No. 8,

District File Number .....

Date Filed 1-12-43

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**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 wit the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**

S. No. 2B
M—8-21-41
I X29288

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. 41109

Registration District No. 165 Primary Registration District No. 425-3 Registrar's No. 8

**1. PLACE OF DEATH**

(a) County: Johnson

(b) City or town: Chilhowee (If outside city or town limits, write "RURAL" and name of township)

(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: — (Specify whether years, months or days)

In this community: 35-yrs

**2. USUAL RESIDENCE OF DECEASED:**

(a) State: Mo (b) County: Johnson

(c) City or town: Chilhowee (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:

3. (a) PRINT FULL NAME: Robert Gilmore

3. (b) If veteran, name war: —

3. (c) Social Security No.: —

4. Sex: M

5. Color or race: B

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

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 78 Months Days If less than one day: hr. min.

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

10. Usual occupation:

11. Industry or business:

MOTHER FATHER

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) Burial (Burial, cremation, or removal) (b) Date thereof: 12/10/42 (Month) (Day) (Year)

(c) Place: burial or cremation: Chilhowee, Mo.

18. (a) Signature of funeral director:

(b) Address:

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

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Dec Day 9 year 1942 hour 12 minute 25 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 | Duration |
|---|---|
| | |
| Due to | |
| 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)

(b) 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: (M. D. or other)

Address: Date signed:

SUPPLEMENTARY