DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 8 1943

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

3311

State File No.

Registration District No. 316 Primary Registration District No. 6075 Registrar's No. 190

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

1. PLACE OF DEATH:
(a) County: St. Francois
(b) City or town: Farmington RURAL, St. Francois
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: State Hospital No. 4 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 Mos 20 Das (Specify whether years, months or days)
In this community 0

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Wayne Co 94
(c) City or town: Piedmont, ~~R.F.D.~~ Rural 0
(If outside city or town limits, write "RURAL")
(d) Street No.: Route 3
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME: GEORGE GILBERT

3. (b) If veteran, name war: Unknown

3. (c) Social Security No.: Unknown

4. Sex: Male

5. Color or race: White

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

6. (b) Name of husband or wife: Mrs. Fannie Brewer (31)

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

7. Birth date of deceased: May (Month) 5 (Day) 1865 (Year)

8. AGE: Years 77 Months 8 Days 10 If less than one day hr. min.

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

10. Usual occupation: Brick Mason

11. Industry or business: Brick Mason

FATHER
12. Name: Samuel W. Gilbert
13. Birthplace: Belfast (City, town, or county) Ireland (State or foreign country)

MOTHER
14. Maiden name: Elizabeth Hawn
15. Birthplace: Vienna (City, town, or county) Ind (State or foreign country)

16. (a) Informant: Records State Hospital No4.
(b) Address: Farmington, Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Jan. 17- 43 (Month) (Day) (Year)
(c) Place: burial or cremation: Masonic Cem. Piedmont,

18. (a) Signature of funeral director: William Coder
(b) Address: Piedmont, Mo

19. (a) Jan. 18, 1943 (Date received local registrar) (b) Byndie Buhrmester (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 15 year 1943 hour 9 minute 35 A.M.

21. I hereby certify that I attended the deceased from October 28th 1942 to Jan. 15 1943; that I last saw him alive on January 15 1943; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Pneumonia	3 days
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy: No 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? No
(Specify type of place)
While at work? (e) Means of injury 0

23. Signature Otto N. Schudde, MD (M. D. or other)
Address State Hosp. Farmington, Mo. Date signed 1-15-43

1196

(Licensed Embalmer's Statement on Reverse Side)

District Health Officer No. 4
District File Number 243-1671
Date Filed 2-5-43

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 William Coder

Licensed Embalmer No. 3723

P. O. Address Piedmont, M

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

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

S. No. 2B
M—8-21-41
P 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. 3311

Registration District No. 316 Primary Registration District No. 6075 Registrar's No. 190

1. PLACE OF DEATH:
(a) County St Francois
(b) City or town Rural
(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

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

3. (a) PRINT FULL NAME George Gilbert
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 May (Month) 1 (Day) 1871 (Year)
8. AGE: Years 72 Months 8 Days If less than one day hr. min.
9. Birthplace (City, town, or county) Ind. (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, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
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 Jan Day 15 year 1943 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 stated above.

	Duration
Immediate cause of death Pneumonia	
Bronchopneumonia	1-8 days
Due to Senile Psychosis	6 mo.
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? (c) Means of injury

23. Signature Otto A. Schudde, MD (M. D. or other)
Address State Hosp. - Farmington, Mo. Date signed

SUPPLEMENTARY