S. No. 2
M—9-4-41
5-17-39
I X29484

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 17855

FILED JUN 3 1943 128

Registration District No.

Primary Registration District No. 5466

Registrar's No. 397

39
0
0

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

1. PLACE OF DEATH:

(a) County GREENE

(b) City or town Rural ~~SPRINGFIELD~~ S Campbell
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
MEDICAL CENTER FOR FEDERAL PRISONERS 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 10 Mos. 19 Days (Specify whether
In this community 10 Months, 19 Days
years, months or days)

2. USUAL RESIDENCE OF DECEASED: 39

(a) State No. Carolina (b) County Scotland 0

(c) City or town Laurinburg, ~~No. Carolina~~ 0
(If outside city or town limits, write "RURAL")

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

(e) Citizen of foreign country? No (Yes or No)

If yes, name country 0

3. (a) PRINT FULL NAME GILCHRIST, Walter D.

3. (b) If veteran, name war Unknown

3. (c) Social Security No. None

4. Sex Male

5. Color or race 2 negro

6. (a) Single, widowed, married, divorced 2 widowed

6. (b) Name of husband or wife Unknown

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

7. Birth date of deceased August (Month) 30, (Day) 1894 (Year)

8. AGE: Years 48 Months 8 Days 13 If less than one day hr. min.

9. Birthplace Red Springs (City, town, or county) No. Carolina (State or foreign country)

10. Usual occupation laborer

11. Industry or business

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

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

16. (a) Informant File

(b) Address

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 5-14-43 (Month) (Day) (Year)

(c) Place: burial or cremation Fayetteville, North Carolina

18. (a) Signature of funeral director Fred C Thieme

(b) Address Springfield, Mo

19. (a) 5-14-43 (Date received local registrar) (b) Dr W E Handley (Registrar's signature)

989

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 13
year 1943 hour 2 minute 10 P.M.

21. I hereby certify that I attended the deceased from June 24, 1942 to May 13, 1943;
that I last saw him alive on May 13, 1943;
and that death occurred on the date and hour stated above.

Immediate cause of death cerebral hemorrhage, (massive) left

Due to hypertension, severe, and arteriosclerosis, severe.

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy massive hemorrhage into left cerebrum & left lateral ventricle

Duration: prior to admission

PHYSICIAN
Underline the cause to which death should be charged statistically.

83a

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 R. W. McComas (M. D. ~~[illegible]~~)

Address MCFP R.W. McCOMAS, Clinical Director Date signed 5-14-43

(Licensed Embalmer's Statement on Reverse Side)

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 Fred C Thieme

Licensed Embalmer No. 2899

P. O. Address Springfield, 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, fact should be so stated above.