

310720

State File No. ....

ILEC DEC 11 1943

Registration District No. 37

Primary Registration District No. 4049

Registrar's No. 27

1. PLACE OF DEATH:

(a) County Boone

(b) City or town Centralia  
(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 1  
(Specify whether 1)

In this community 41 years  
years, months or days (Specify whether)

3. (a) PRINT FULL NAME IMO GILLAM

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 Married

6. (b) Name of husband or wife Chas. Gilliam

6. (c) Age of husband or wife if alive 68 years

7. Birth date of deceased: Sept 2 1902  
(Month) (Day) (Year)

8. AGE: Years 41 Months 1 Days 22  
If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business

MOTHER FATHER

12. Name Joseph R. Cornelius

13. Birthplace Louisville Ky  
(City, town, or county) (State or foreign country)

14. Maiden name Sarah A. Allison

15. Birthplace McClain Co. Ill.  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. H. B. Pashan

(b) Address Boone Mo

17. (a) (Burial, cremation, or removal) Buried (b) Date thereof 10-20-43  
(Month) (Day) (Year)

(c) Place: burial or cremation Centralia Mo

18. (a) Signature of funeral director Mrs. Schaeffer

(b) Address Centralia Mo

19. (a) 1945-1943 (b) Chas. D. Wright  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Boone 10

(c) City or town Centralia  
(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 ✓

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 24  
year 1943 hour 6 minutes 5 P M.

21. I hereby certify that I attended the deceased from Corona Pass 19...  
that I last saw him alive on ... 19...  
and that death occurred on the date and hour stated above.

Immediate cause of death Poisoning

Due to Self Administered

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy none

Duration

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) Suicide

(b) Date of occurrence

(c) Where did injury occur? Home  
(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 Marion Madam (M. D. or other) Cornea

Address Columbia Mo Date signed

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

AUG 19 1953

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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 *W. M. ...*.....

Licensed Embalmer No. *4213*.....

P. O. Address *Centerville 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.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 156c.

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Boone  
(b) City or town Centralia  
(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)  
In this community 4 yrs.  
years, months or days

3. (a) PRINT FULL NAME Imo Gilliam

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

4. Sex 7 5. Color or race w 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive 68 years

7. Birth date of deceased Sept. (Month) (Day) (Year)

8. AGE: Years 41 Months 2 Days 2 If less than one day \_\_\_\_\_ min.

9. Birthplace Mo. (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 \_\_\_\_\_ (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 Oct. Day 27 year 1943 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 Self administered

Due to lung taken from Sodium Chloride

Other conditions \_\_\_\_\_ (include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_ Of operations \_\_\_\_\_

Of autopsy none

Duration

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) suicide  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? Columbia Boone Mo (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 Wain McLean (M.D. or other) \_\_\_\_\_  
Address Columbia Mo Date signed \_\_\_\_\_

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

SUPPLEMENTARY

37120