

3. No. 2  
1-8-43  
5-17-39  
X37823

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

14154

State File No. \_\_\_\_\_

FILED MAY 11 1944

Registration District No. 43

Primary Registration District No. 1000

Registrar's No. 386

1. PLACE OF DEATH:

(a) County Richmond  
(b) City or town St. Joseph  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution Hartssock Hoop O  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution about 1 week  
In this community Harrison Co. Mo. 2 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Harrison  
(c) City or town Bethany 71  
(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 \_\_\_\_\_

3. (a) PRINT FULL NAME Rosco Gillespie

3. (b) If veteran, name war No 3. (c) Social Security 486-07-0125

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced married  
(b) Name of husband or wife Isabelle Gillespie 6. (c) Age of husband or wife if alive 40 years  
7. Birth date of deceased 9 - 1 - 1900  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 26 year 1944 hour 1 pm minute 50 M.  
21. I hereby certify that I attended the deceased from 21, 1944 to 26, 1944  
that I last saw live on Cape 26 and that death occurred on the date and hour stated above.

Immediate cause of death Perilious Anemia  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Duration

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? \_\_\_\_\_ (Means of injury)  
23. Signature Dr. W. E. Hartssock M.D.  
Address 1207 Franklin St. Bethany Mo.

8. AGE: Years 43 Months 7 Days 25 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Bethany (Rural) Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation St. Joseph County Clerk

11. Industry or business Joseph Gillespie

12. Name Joseph Gillespie

13. Birthplace Harrison Co. Mo.  
(City, town, or county) (State or foreign country)

14. Maiden name Coraline Henderson

15. Birthplace Harrison Co. Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant Isabelle Gillespie

(b) Address Bethany Mo.

17. (a) Burial (b) Date thereof 4-30-1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Miriam Cemetery

18. (a) Signature of funeral director W. H. Hays  
(b) Address Bethany Mo.

19. (a) 4/30/44 (b) Oliver Herzog  
(If also received local registrar) (Registrar's signature)

1233

(Licensed Embalmer's Statement on Reverse Side)

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

MOTHER FATHER

**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..... *J. W. Haas*.....

Licensed Embalmer No..... *1078*.....

P. O. Address..... *Bethany, W. Va.*.....

**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.**