

FILED NOV 13 1944

Registration District No. 21

Primary Registration District No. 5829

Registrar's No. 41

1. PLACE OF DEATH:

(a) County New Madrid
(b) City or town Jay Wye Portage Twp
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location) 1
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community Life years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County New Madrid
(c) City or town Jay Wye Portage Twp
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Wilma Ruth Gilliam

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

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced Infant
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Sept 7 1944
(Month) (Day) (Year)

8. AGE: Years _____ Months 1 Days 18 If less than one day _____ hr. _____ min.

9. Birthplace Jay Wye, Mo (City, town, or county) (State or foreign country)

10. Usual occupation Infant

11. Industry or business _____

MOTHER FATHER { 12. Name Jessie D. Gilliam
13. Birthplace Missouri (City, town, or county) (State or foreign country)
14. Maiden name Marie Combs
15. Birthplace Missouri (City, town, or county) (State or foreign country)

16. (a) Informant Jessie D. Gilliam
(b) Address Jay Wye, Mo

17. (a) Burial (b) Date thereof 10-19-44
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Portageville Cemetery

18. (a) Signature of funeral director Grunde

(b) Address _____
19. (a) 10-27-44 (b) Ellen DeLisle
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 18 year 1944 hour 12 minute _____ A. M.

21. I hereby certify that I attended the deceased from Oct 18 1944 to Oct 18 1944 that I last saw her alive on Oct 18 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Dysentery (Bacillary)
Bronchiopneumonia
Due to dysentery bacillary
type undetermined
Due to malnutrition

Duration 2 or 3 days
2 weeks
1 mo.

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations 27a
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? _____

While at work? _____ (Specify type of place) (c) Means of injury _____

23. Signature John Killiam (M. D. or other) _____
Address Portageville Mo Date signed 10-27-44

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

72000

RECEIVED

District Health Office No. 2,

District File Number 114-1521

Date Filed 11-10-44

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 ^{not}.....

....., Registered Apprentice No.
working under my personal supervision.

Signed Noel C. Dean.....

Licensed Embalmer No. 3941.....

P. O. Address Portsmouth.....

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.