

S. No. 2  
M-8-43  
5-17-39  
K37823

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 1717

FILED FEB 13 1945  
Registration District No. 22

Primary Registration District No. 1000

Registrar's No. 85

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

1. PLACE OF DEATH:  
(a) County Buchanan  
(b) City or town St. Joseph  
(If outside city or town limits, write "RURAL," and name of township)  
(c) Name of hospital or institution:  
917 1/2 So. 8th St.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 3 months  
(Specify whether  
In this community 12 years  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Buchanan  
(c) City or town St. Joseph  
(If outside city or town limits, write "RURAL")  
(d) Street No. 917 1/2 So. 8th St.  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country 0

3. (a) PRINT FULL NAME Samuel Gillian  
3. (b) If veteran, name war none  
3. (c) Social Security No. 500-07-8431

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Jan day 21,  
year 1945 hour 5 minute 00 P.M.

4. Sex Male 5. Color or race White  
6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Margaret Ellen Gillian  
6. (c) Age of husband or wife if alive 40 years  
7. Birth date of deceased May 15 1899  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from  
Jan. 21, 1945 to Jan. 21, 1945  
that I last saw h. alive on 1-21- 1945  
and that death occurred on the date and hour stated above.

8. AGE: Years 53 Months 8 Days 7  
If less than one day 5 hr. 30 min.

Immediate cause of death Coronary thrombosis Duration Don't know

9. Birthplace Cuba, Missouri  
(City, town, or county) (State or foreign country)

Due to Arterial sclerosis  
Due to

10. Usual occupation Laborer

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

11. Industry or business none

Major findings: 940  
Of operations --

12. Name Unknown

Of autopsy --

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

14. Maiden name Unknown  
(City, town, or county) (State or foreign country)

15. Birthplace " "  
(City, town, or county) (State or foreign country)

16. (a) Informant Margaret E. Gillian (Wife)

(b) Address 917 1/2 So. 8th St., City

17. (a) Burial (b) Date thereof 1-23-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation City Cemetery

18. (a) Signature of funeral director John C. Mupp  
(b) Address 6054 Pryor Ave., City

19. (a) 1-23-45 (b) John C. Mupp  
(Date received local registrar) (Registrar's signature)

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) (e) Means of injury --

23. Signature Charles H. Wenzel, M.D.  
(M. D. or other)

Address 221A Kirkpatrick Bldg Date signed 1/23/45

1377

(Licensed Embalmer's Statement on Reverse Side)

1945

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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 ~~.....~~.....

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

Signed

*John E. Rupp*

Licensed Embalmer No. *3986*

P. O. Address. *St Joseph, 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.**