

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

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

FILED MAR 28 1945  
43

Registrar's No. 57

Registration District No. \_\_\_\_\_

Primary Registration District No. 5135

1. PLACE OF DEATH:

(a) County Butler  
(b) City or town Fisk *not Hillburg*  
(c) Name of hospital or institution: *FISK MO*  
(d) Length of stay: In hospital or institution 25 years  
In this community 25 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County *Stoddard*  
(c) City or town Fisk, rural  
(d) Street No. \_\_\_\_\_  
(e) Citizen of foreign country? no

3. (a) PRINT FULL NAME

Andrew Wilburn Gillihan  
3. (b) If veteran, name war none  
3. (c) Social Security No. none

4. Sex male  
5. Color or race white  
6. (a) Single, widowed, married, divorced, divorced  
6. (b) Name of husband or wife \_\_\_\_\_  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased February 9 1871

8. AGE: Years 74 Months \_\_\_\_\_ Days 7  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace White County Illinois  
laborer (City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business farm

12. Name John H. Gillihan  
13. Birthplace Smith County, Tenn  
14. Maiden name Nancy D. Jones  
15. Birthplace Smith County, Tenn

16. (a) Informant E.C. Gillihan  
(b) Address Fisk, Missouri

17. (a) *burial* (b) Date thereof Feb 18, 1945  
(c) Place: burial or cremation *McL Hill*

18. (a) Signature of funeral director *M. S. Shaw*

(b) Address Fisk, Missouri

19. (a) *2-22-45* (b) *Belle Turner*  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 16 day Feb. year 1945 hour 4 minute 40 p. M.  
21. I hereby certify that I attended the deceased from Feb 10 1945 to Feb 16 1945  
that I last saw him alive on Feb 13 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death: Carcinoma of liver  
Due to Carcinoma of sigmoid

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

Major findings: Of operations *462*  
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? \_\_\_\_\_  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_  
33. Signature *W. W. ...* (M. D. or other) \_\_\_\_\_  
Address *Fisk, Missouri* Date signed *2-19-45*

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

MOTHER FATHER

RECEIVED  
District Health Office N  
District File Number 345-4  
Date Filed 3/23/4

**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 Wallace N. Fitch

Licensed Embalmer No. 3859

P. O. Address Poplar Bluff

**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.**

Registration District No. 43

Primary Registration District No. 5135

1. PLACE OF DEATH:

(a) County Butler  
(b) City or town Cause - Ash Hill  
(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 \_\_\_\_\_ years, months or days)

3. (a) PRINT FULL NAME Andrew W. Gillihan

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

7. Birth date of deceased Feb 9 (Month) (Day) (Year)

8. AGE: Years 74 Months \_\_\_\_\_ Days \_\_\_\_\_ (Unless than one day) min. \_\_\_\_\_

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 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) \_\_\_\_\_ (Burial, cremation, or removal) (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) 3/30/45 (Date received by registrar) (b) Belle Timme (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 Feb day 6 year 1945 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 \_\_\_\_\_

Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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)

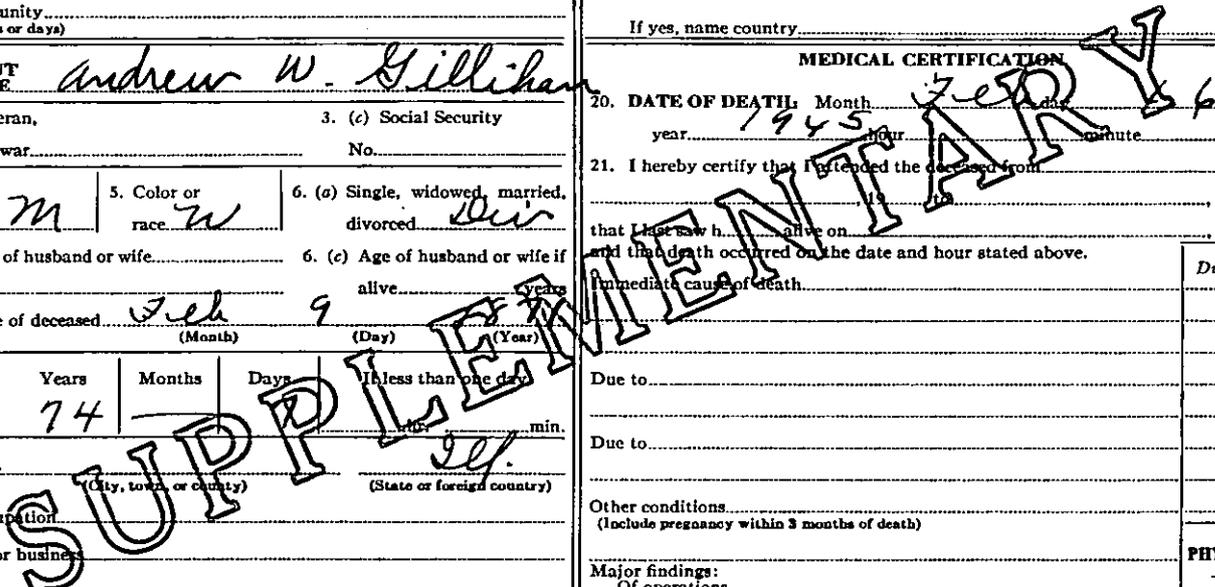
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M, D. or other)

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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



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