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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 5 1946

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **9412**
Registrar's No. **3**

Registration District No. **67**

Primary Registration District No. **4118**

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

1. PLACE OF DEATH:

(a) County **Christian**
(b) City or town **Sparta**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **1**
(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 years**
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Christian**
(c) City or town **Sparta** (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? **0** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Elizabeth Gilland**

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 **Widow**
6. (b) Name of husband **Alexander Gilland** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **Dec 28 1864**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	80	1	3	hr. min.

9. Birthplace **Tennessee**
(City, town, or county) (State or foreign country)

10. Usual occupation **House wife**

11. Industry or business **Farmer**

MOTHER FATHER { 12. Name **Way** **Way**

13. Birthplace **unknown** **9**
(City, town, or county) (State or foreign country)

14. Maiden name **Ann Teet Way**

15. Birthplace **unknown** **9**
(City, town, or county) (State or foreign country)

16. (a) Informant **Ivan Gilland (son)**

(b) Address **Sparta, Mo**

17. (a) **Garrison** (b) Date thereof **2-1-'45**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Garrison, Mo**

18. (a) Signature of funeral director **T. B. Chubb**

(b) Address **Sparta, Mo**

19. (a) **4-3-1946** (b) **Mrs S. M. Johnson**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan** - day **31st**
year **1945** hour **6** minute **AM**

21. I hereby certify that I attended the deceased from **Jan - 29**, 1945, to **Jan - 31**, 1945
that I last saw her alive on **Jan 30**, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death **7 hypostatic pneumonia 2 days**

Due to **Chronic valvular heart disease** **6 mo**

Due to _____

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

Major findings: **920**
Of operations _____
Of autopsy _____

Duration
2 days
6 mo
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 **Pharm H. Johnson** (M. D. or other) **4460**
Address **Sparta, Mo** Date signed **2/1/45**

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 T. B. Chaffin
Licensed Embalmer No. 2152
P. O. Address Orank Md.

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. April
Registrar's No. 3

Registration District No. 67 Primary Registration District No. 4118

1. PLACE OF DEATH:

(a) County Christian
(b) City or town Sparta
(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

Elizabeth Gilliland

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race w

6. (a) Single, widowed, married, divorced w

6. (b) Name of husband or wife

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

7. Birth date of deceased Dec 28 1906
(Month) (Day) (Year)

8. AGE:

Years 80

Months

Days

If less than one day

min.

9. Birthplace

(City, town, or county)

Tenn
(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) (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) (Date received local registrar)

(b) Mrs J M Johnson
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Christian
(c) City or town Sparta, Tenn Sparta
(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 Jan year 1945 hour 1 minute 15 M.

21. I hereby certify that I attended the deceased from 1945 to 1945

that I last saw him alive on 1945, 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

MOTHER FATHER

SUPPLEMENTARY

9412