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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 11 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 13659

Registration District No. 153 Primary Registration District No. 5579 Registrar's No. 14

1. PLACE OF DEATH:

(a) County Jasper

(b) City or town Oronogo (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: R#1, Oronogo (If not in hospital or institution, write street number or location)

(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 Jasper

(c) City or town Oronogo (If outside city or town limits, write "RURAL") 49

(d) Street No. R#1 (If rural, give location) 0

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Helen Faye Gillard

3. (b) If veteran, name war

3. (c) Social Security No.

4. Female

5. Color or race White

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

6. (b) Name of husband or wife Single

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

7. Birth date of deceased February (Month) 17 (Day) 1924 (Year)

8. AGE: Years 21 Months 2 Days 3 If less than one day hr. min.

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

10. Usual occupation Newman Dept Store

11. Industry or business

FATHER
12. Name Jess Gillard
13. Birthplace (City, town, or county) Wis (State or foreign country)

MOTHER
14. Maiden name Lois Lowery
15. Birthplace (City, town, or county) Wis (State or foreign country)

16. (a) Informant Jess Gillard

(b) Address R#1 Oronogo, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof April 23 1945 (Month) (Day) (Year)

(c) Place: burial or cremation Weaver Cem

18. (a) Signature of funeral director Webb City Und Co

(b) Address Webb City, Mo

19. (a) Apr. 23 1945 (Date received local registrar) (b) Mrs Lillie Lagle (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month April day 20 year 1945 hour 5 minute P. M.

21. I hereby certify that I attended the deceased from Apr 9 th 45 to Apr 20.45 1945 that I last saw her alive on Apr 20.45 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Uraemic Poisioning

Due to Undetermined

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations Undergone an abdominal Opeeation Feb 24.1945

Of autopsy

Duration

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

PHYSICIAN — Underline the cause to which death should be charged statistically.

132.

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? (e) Means of injury

23. Signature [illegible] (M. D. or other)

Address Neck City. Mo 4-23.45 Date signed

(Licensed Embalmer's Statement on Reverse Side)

45-4-365

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 myself,

....., Registered Apprentice No.....,

working under my personal supervision.

Signed Clay Lee M. Johnston

Licensed Embalmer No. 4304

P. O. Address Weeb City, 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.