V. S. No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 9 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 33174

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 1183

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: 2806 Patee St.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community Lifetime
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. 2806 Patee St.
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Robert Joseph Gilborne

3. (b) If veteran, name war None
3. (c) Social Security No. 493-18-1295

4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Madeline H. Gilborne
6. (c) Age of husband or wife if alive 34 years
7. Birth date of deceased April (Month) 13 (Day) 1901 (Year)

8. AGE:

Years	Months	Days	If less than one day
44	6	19	hr. min.

9. Birthplace St. Joseph (City, town, or county) Missouri (State or foreign country)
10. Usual occupation Chief Deputy Auditor
11. Industry or business County Court House

FATHER
12. Name Robert J. Gilborne
13. Birthplace Ballingery Co. Limerick, Ireland (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Mary Bowen
15. Birthplace Ballingary Co. Limerick, Ireland (City, town, or county) (State or foreign country)

16. (a) Informant Madeline H. Gilborne
(b) Address 2806 Patee St.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 5, 1945 (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Olivet Cemetery
18. (a) Signature of funeral director Herman W. Sidenfaden
(b) Address 1802 Union St. St. Joseph, Mo.
19. (a) Nov. 5, 1945 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 2nd year 1945 hour 8 minute 30 A.M.
21. I hereby certify that I attended the deceased from Nov 2nd 1945 to ..., 19...; Vieged
that I last saw h... alive on ..., 19...;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Suicide by hanging	
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) Suicide
(b) Date of occurrence Nov 2nd 1945
(c) Where did injury occur? St Joseph, Mo. (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home (Specify type of place)
While at work? no (e) Means of injury Rope
23. Signature B. W. Tadlock Coroner (M. D. or other)
Address King Hill Bldg Date signed 11/3/45

1428

(Licensed Embalmer's Statement on Reverse Side)

NOV 19 1945

NOV 9 1945

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~~ Elmer Thomas, Registered Apprentice No. ....., working under my personal supervision.

Signed Elmer Thomas

Licensed Embalmer No. 2640

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.