

Registration District No. 132

Primary Registration District No. 3021

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Wendy  
(b) City or town Trenton  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Wright's Mem. Hosp.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 7 days  
In this community Life time (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Wendy  
(c) City or town Trenton  
(If outside city or town limits, write "RURAL")  
(d) Street No. 27 + Lulu  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME A. EMIT GILLASPIE

3. (b) If veteran, name war No 3. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

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

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

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

9. Birthplace Farmland Ind. (City, town, or county) (State or foreign country)

10. Usual occupation Painter

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

12. Name Daniel Gillaspie

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

14. Maiden name Rains

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

16. (a) Informant Mrs. O.R. Rooks

(b) Address 303 E 8th

17. (a) Burial (b) Date thereof 11 23 45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation 200 E. Com Trenton

18. (a) Signature of funeral director Superior Funeral Home

(b) Address Trenton MO

19. (a) 11-23-45 (b) Drene Jarr  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 21  
year 1945 hour 11:30 minute P M.

21. I hereby certify that I attended the deceased from Nov 20  
1945 to Nov 21 1945  
that I last saw him alive on Nov 21  
and that death occurred on the date and hour stated above.

Immediate cause of death Head injury due to accidental fall on stairs at home  
Due to Chronic Alcoholism  
Duration 184

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence 40

(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 E.A. Duffey (M. D. or other) \_\_\_\_\_

Address Trenton MO Date signed Nov 21 1945

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

RECEIVED

District Health Officer No. 11,

District File Number.....

Date Filed.....

**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 *Wesley H Bradford*

Licensed Embalmer No. *4370*

P. O. Address *Fenton 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.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. Jan  
Registrar's No. \_\_\_\_\_

Registration District No. 132 Primary Registration District No. 3021

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

1. PLACE OF DEATH: Grundy  
 (a) County Grundy  
 (b) City or town Greentown  
 (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 A. Ernie Gillaspie  
 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 wid

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

7. Birth date of deceased \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

8. AGE: Years 72 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ 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) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
 (Burial, cremation, or removal)  
 (c) Place: burial or cremation \_\_\_\_\_

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

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
 (Date received local registrar) (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 \_\_\_\_\_ Day \_\_\_\_\_ Year 1945 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
 21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_  
 ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

22. If death was due to external causes, fill in the following:  
 (a) Accident, suicide, or homicide (specify) Accident  
 (b) Date of occurrence 11-20-45  
 (c) Where did injury occur? Grundy Greentown Mo. (City or town) (County) (State)  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? Home  
 While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury Fall

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
 Date signed \_\_\_\_\_

SUPPLEMENTARY

Duration \_\_\_\_\_  
 PHYSICIAN \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

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