S. No. 2
M—8-43
5-17-39
P I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 29 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 42138

Registration District No. 278 Primary Registration District No. 4413 Registrar's No.

1. PLACE OF DEATH:
(a) County: PIKE
(b) City or town: FRANKFORD (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 years, months or days)
In this community: 8 YEARS.

2. USUAL RESIDENCE OF DECEASED:
(a) State: MISSOURI (b) County: PIKE 82
(c) City or town: FRANKFORD (If outside city or town limits, write "RURAL") 0
(d) Street No.: RURAL - SOUTH (If rural, give location) 0
(e) Citizen of foreign country? No (Yes or No) 0
If yes, name country:

3. (a) PRINT FULL NAME: LELA MAY GILBERT
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: MARRIED
6. (b) Name of husband or wife: JOHN GILBERT
6. (c) Age of husband or wife if alive: 51 years
7. Birth date of deceased: APRIL (Month) 2 (Day) 1882 (Year)

8. AGE: Years 63 Months 6 Days 29 If less than one day hr. min.

9. Birthplace: MONROE Co (City, town, or county) Mo. (State or foreign country)
10. Usual occupation: HOUSEWIFE
11. Industry or business:
FATHER 12. Name: THOMAS HARRISON
FATHER 13. Birthplace: (?) (City, town, or county) (?) (State or foreign country) 9
MOTHER 14. Maiden name: FANNIE WEST
MOTHER 15. Birthplace: (?) (City, town, or county) (?) (State or foreign country) 9
16. (a) Informant: MAUDIE WEST
(b) Address: DETROIT WIS.
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof: Nov 4 '45 (Month) (Day) (Year)
(c) Place: burial or cremation: FRANKFORD MO
18. (a) Signature of funeral director: Fields and Son
(b) Address: Frankford, Mo.
19. (a) 11/5/45 (Date received local registrar) (b) Margaret E. Stephens (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 1 year 1945 hour 4 minute 10 A.M.
21. I hereby certify that I attended the deceased from July 26 1, 1945 to Oct. 25 1, 1945; that I last saw her alive on Oct. 25 1945; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Heart Failure	
Due to: Cirrhosis of liver	
Due to: Cholecystitis	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations: /	
Of autopsy: 1945	

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? (Specify type of place)
While at work? (e) Means of injury:
23. Signature: E. P. Hansen (M. D. or other) D.O.
Address: Frankford Mo. Date signed 11/3/45

1593 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 13-45-1934
Date Filed DEC 20 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.....

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

working under my personal supervision.

Signed Joel Francis Megown

Licensed Embalmer No. 4095

P. O. Address Trenton, 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.