

S. No. 2  
OM-5-43  
v. 5-17-39  
I X36671

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **13142**  
Registrar's No. **1620**

**FILED** APR 17 1946  
Registration District No. **17**

Primary Registration District No. **1002**

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

**1. PLACE OF DEATH:**

(a) County Jackson

(b) City or town Kansas City

(c) Name of hospital or institution: Osteopathic Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 Week (Specify whether years, months or days)

In this community 45 Years

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Jackson

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

(d) Street No. 3218 Olive  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** Walter R. Gillespie

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 Emily Gillespie

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

7. Birth date of deceased 9 9 1860  
(Month) (Day) (Year)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month April day 4th  
year 1946 hour 12 minute 35 P.M.

21. I hereby certify that I attended the deceased from March 28, 1946 to April 4, 1946  
that I last saw him alive on April 4, 1946  
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>85</u>	<u>6</u>	<u>25</u>	hr. min.

Immediate cause of death Be-lateral Labor Pneumonia

Due to Cardio-Vascular Real Syndrome

Due to Carcinoma of the Penis.

Other conditions: \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: Biopsy 512  
Of operations Squamous Cell Carcinoma  
Of autopsy \_\_\_\_\_

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

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

10. Usual occupation Retired Farmer

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

**MOTHER** { 12. Name William Gillespie

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

14. Maiden name Emma Russell

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

16. (a) Informant Mrs. Anna Hill

(b) Address 3240 Bellefontaine

17. (a) Burial (b) Date thereof 4-6-1946  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Marys

18. (a) Signature of funeral director Mrs. C.L. Forster

(b) Address Kansas City Missouri

19. (a) 4-5-46 (b) Geraldine Holmes  
(Date received local registrar) (Registrar's signature)

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 2

23. Signature James A. Di Renna (M. D. or other) D.O.  
Address Osteopathic Hospital Date signed 4/4/46

12040

FEB 24 1947

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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.....

*Joe B. Yoder*

Licensed Embalmer No. 4173

P. O. Address. K.C. 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.**