S. No. 2
M—8-43
5-17-39
PI X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 15422

FILED MAY 7 1946

Registration District No. 338 Primary Registration District No. 6148 6501 Registrar's No.

1. PLACE OF DEATH:
(a) County Stoddard
(b) City or town Bloomfield Route # 1
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: None
(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 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Stoddard 103
(c) City or town Bloomfield R. # 1 0
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME FANNIE B. GILLISPIE

3. (b) If veteran, name war ---

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Widow 2

6. (b) Name of husband or wife Deceased

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

7. Birth date of deceased MARCH (Month) 6th, (Day) 1864 (Year)

8. AGE: Years 82 | Months 1 | Days 2 | If less than one day ____ hr. ____ min.

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

10. Usual occupation Housewife

11. Industry or business

MOTHER FATHER

12. Name Augustine Brown

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

14. Maiden name Sarah West

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

16. (a) Informant Mrs. Exra Bacon
(b) Address Bloomfield, Mo. Route # 1.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 10-46 (Month) (Day) (Year)

(c) Place: burial or cremation Leora cemetery

18. (a) Signature of funeral director Chiles Und. Co.
(b) Address Bloomfield, Mo.

19. (a) 4-30-46 (Date received local registrar) (b) Rose Webber (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 8th year 1946 hour 6:30 minute A. M.

21. I hereby certify that I attended the deceased from Nov. 10 1945, 19__, to April 8, 1946, that I last saw h. alive on April 7, 1946; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Chronic Myocarditis	10 yrs
Due to:	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	

Major findings:
Of operations None performed
Of autopsy None performed.

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 D. D. Davis (M. D. or other) MD
Address Bloomfield Mo. Date signed April 9, 1946

255 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No. 2,
District File Number 2-46-~~115~~ 5
Date Filed 3-6-46

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 Lulu Cooper

Licensed Embalmer No. 3499

P. O. Address Bloomfield, 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.