

No. 2
8-43
8-17-39
X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **24136**

FILED AUG 4 1946
Registration District No. _____

Primary Registration District No. **3035**

Registrar's No. **50**

1. PLACE OF DEATH:
(a) County **Lafayette**
(b) City or town **Lexington**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1920 South 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 **All her life**
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Lafayette** **54**
(c) City or town **Lexington** **3**
(If outside city or town limits, write "RURAL")
(d) Street No. **1920 South St.** **2**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT **FANNIE GILLEN**
FULL NAME
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____
4. Sex **Female** / 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Single**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **Jan. 6 1873**
(Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **July** day **28th**
year **1946** hour **8** minute **20** A.M.
21. I hereby certify that I attended the deceased from **28 July**
1946 to **28 July** **1946**
that I last saw him alive on **July 28** **1946**
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
73 6 22 hr. min.

Immediate cause of death **Cerebral thrombosis** Duration _____
Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

9. Birthplace **Lexington Mo.**
(City, town, or county) (State or foreign country)
10. Usual occupation **At home**

Major findings:
Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

MOTHER FATHER

11. Industry or business _____
12. Name **John L. Gillen**
13. Birthplace **Germany** **4**
(City, town, or county) (State or foreign country)
14. Maiden name **Anna Ziele**
15. Birthplace **Switzerland** **5**
(City, town, or county) (State or foreign country)

16. (a) Informant **Miss Laura Gillen**
(b) Address **Lexington, Mo.**
17. (a) **Burial** (b) Date thereof **July 30, 1946**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Lexington, Mo.**
18. (a) Signature of funeral director **James F. Tempel**
(b) Address **Lexington, Mo.**
19. (a) **31 Aug 1946** (b) **Thomas E. Eastburn**
(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 _____
23. Signature **Ben H. Brashear** (M. D. or other) _____
Address **Lexington Mo** Date signed **7/28/46**

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

RECEIVED

District Health Officer No. 8,

Case File Number

Date Filed 8-3-48

MAR 2 1948

APR 20 1950

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 Leo McKeon

Licensed Embalmer No. 2983

P. O. Address Leungton, Pa.

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.