

Registration District No. 217

Primary Registration District No. 6786

Registrar's No. 65-

1. PLACE OF DEATH:

(a) County Mississippi  
 (b) City or town Charleston, Rural  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
R#3, 6 mi. E. of Charleston. 3  
(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 13 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Mississippi  
 (c) City or town Charleston, Rural  
(If outside city or town limits, write "RURAL")  
 (d) Street No. R#3, 6 mi. E. of Charleston  
(If rural, give location)  
 (e) Citizen of foreign country? No. (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Joe Gillmore

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

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

6. (b) Name of husband or wife Luticia Gillmore 6. (c) Age of husband or wife if alive 68 years

7. Birth date of deceased: January 1, 1900  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>46</u>	<u>6</u>	<u>9</u>	hr. _____ min. _____

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

10. Usual occupation Sharecropper

11. Industry or business Farming

MOTHER FATHER { 12. Name Unknown  
 13. Birthplace Unknown  
(City, town, or county) (State or foreign country)  
 14. Maiden name Unknown  
 15. Birthplace Unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant Luticia Gillmore

(b) Address R#3, Charleston, Missouri

17. (a) Burial (b) Date thereof 7-10-1946  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove Cemetery

18. (a) Signature of funeral director Joe R. Nunnellee

(b) Address Charleston, Missouri.

19. (a) 7-15-46 (b) Mrs. John Bondurant  
(Date received local registrar) (Registrar's signature)

CORONER'S MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 10th  
 year 1946 hour 12:00 Noon M.

21. I hereby certify that I attended the deceased from Attended as Coroner 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 Shot Wounds inflicted by authorized officers of Law - Namely - Sheriff of Miss County Mo. + State Highway Patrol officers - shot by officers in self defense in line of duty in attempting to arrest deceased on State Warrant for arrest  
 Other conditions (Include pregnancy within 3 months of death)  
Shot wounds - From base of skull to top of head forward. From left to right, wound in abdomen.

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

22. If death was due to external causes, fill in the following: OM, R#3

(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)

23. Signature Joe R. Nunnellee (M. D. or other) 3  
 Address Charleston, Mo Date signed 7-11-46

RECEIVED

District Health Office

District File Number 246

Date Filed 2-22-4

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.....

Licensed Embalmer No..... 4413

P. O. Address..... Charleston, W

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

Registration District No. 217

Primary Registration District No. 5786

1. PLACE OF DEATH:

(a) County Mississippi  
(b) City or town Rural  
(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 Joe Hillmore  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex m 5. Color or race B 6. (a) Single, widowed, married, divorced m

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

7. Birth date of deceased Jan (Month) 1 (Day) 1946 (Year)

8. AGE: Years 46 Months 6 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 \_\_\_\_\_

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 \_\_\_\_\_ year 1946 (month) \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him/her \_\_\_\_\_ alive on \_\_\_\_\_ 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 \_\_\_\_\_

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

(a) Accident, suicide, or homicide (specify) JUSTIFIABLE HOMICIDE

(b) Date of occurrence 7/10/46 RESISTING ARREST - 1

(c) Where did injury occur? RFD Charleston Mo. (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? On farm

While at work? no (Specify type of place) (e) Means of injury Shot

23. Signature Dr. J. Hillmore (M. D. or other) Dr. J. Hillmore  
Address Charleston, Mo Date signed 8/8/46

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING INK

23226

24374