

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **41266**

FILED DEC 23 1946

Registration District No. **187**

Primary Registration District No. **5694**

Registrar's No. **147**

1. PLACE OF DEATH:

(a) County **Livingston**
(b) City or town **Rural**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
R.F.D. #1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **1**
(Specify whether
In this community **Life**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Livingston**
(c) City or town **Chillicothe**
(If outside city or town limits, write "RURAL")
(d) Street No. **R.F.D. #1**
(If rural, give location)
(e) Citizen of foreign country? **No.** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Thomas F. Gilchrist**

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

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widowed**
6. (b) Name of husband or wife **Lura Gilchrist** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **June 26 1872**
(Month) (Day) (Year)

8. AGE: Years **74** Months **5** Days **6** If less than one day _____ hr. _____ min.

9. Birthplace **Livingston Co Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

11. Industry or business _____

12. Name **Hugh Gilchrist**

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

14. Maiden name **Elizabeth Ray**

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

16. (a) Informant **Mr. Hugh Gilchrist**

(b) Address **Cassie Mills, Ill.**

17. (a) **Burial** (b) Date thereof: **12-5-1946**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Catholic Cemetery**

18. (a) Signature of funeral director **Donald Gordon**

(b) Address **Chillicothe, Mo.**

19. (a) **Dec-4-46** (b) **Francis B. Neill**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec** day **2**
year **1946** hour **9** minute **10-P-M.**

21. I hereby certify that I attended the deceased from **Dec 2** 19**46** to **Dec 2** 19**46**
that I last saw him alive on **Dec 2** 19**46**
and that death occurred on the date and hour stated above.

Immediate cause of death **Perforated Duodenal Ulcer** Duration **10 hours**
Due to **Duodenal Ulcer** **1 year**

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: **63**
Of operations **10**
Of autopsy _____

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 **W. C. Colby** (M. D. or other) _____
Address **Chillicothe, Mo.** Date signed **12/3/46**

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

40673

JAN 20 1947

DISTRICT HEALTH OFFICE
Cameron, Mo.

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 Ronald Gardner

Licensed Embalmer No. 4191

P. O. Address Chillicothe, 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.