

FILED MAY 23 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 19821

Registration District No. 324

Primary Registration District No. 4470

Registrar's No. 96

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

1. PLACE OF DEATH:

(a) County Saline
(b) City or town Arrow Rock, Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Home
(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

3. (a) PRINT FULL NAME Mary Gilpin

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 Single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: Unknown
(Month) (Day) (Year)

8. AGE: Years About 73 Months _____ Days _____ If less than one day hr. _____ min. _____

9. Birthplace: Saline County Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation: House keeper

11. Industry or business: _____

12. Name: John Gilpin

13. Birthplace: Unknown Virginia
(City, town, or county) (State or foreign country)

14. Maiden name: Margaret Wagoner

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

16. (a) Informant: Miss Helen Green

(b) Address: Arrow Rock, Missouri

17. (a) Burial (b) Date thereof: May 5, 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Arrow Rock cemetery

18. (a) Signature of funeral director: Campbell Harris

(b) Address: Marshall, Mo.

19. (a) May 5-1947 (b) Frederic T. Gray
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Saline
(c) City or town Arrow Rock
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 3
year 1947, hour 5:30 minute A. M.

21. I hereby certify that I attended the deceased from Feb 1947 to May 3 1947
that I last saw her alive on May 3 1947
and that death occurred on the date and hour stated above.

Immediate cause of death: Chronic myocarditis & arteriosclerosis
Due to: Hypertension
Due to: _____

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

Major findings: 930
Of operations: _____
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? _____

23. Signature: Frederic T. Gray (M.D. or other) _____
Address: Marshall Date signed: 5/5/47

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed 5-16-47

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 W. Campbell Jr.

Licensed Embalmer No. 3469

P. O. Address Marshall Inc

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.