

S. No. 2  
 M-5-43  
 7-5-17-39  
 I X34671

DEPARTMENT OF COMMERCE  
 BUREAU OF THE CENSUS  
 FILED SEP 25 1947

THE STATE BOARD OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

State File No. **31910**  
 Registrar's No. **25**

Registration District No. **241** Primary Registration District No. **58219**

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

**1. PLACE OF DEATH:**  
 (a) County New Madrid  
 (b) City or town Rural - Portage Twp.  
(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 \_\_\_\_\_)

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State Mo (b) County New Madrid  
 (c) City or town Portage Twp.  
(If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_  
(If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No) **0**  
 If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** Martha McAdam Gilliom  
 3. (b) If veteran, name war \_\_\_\_\_  
 3. (c) Social Security No. \_\_\_\_\_

**MEDICAL CERTIFICATION**  
 20. DATE OF DEATH: Month 26 Aug day Aug  
 year 1947 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Married  
 6. (b) Name of husband or wife Matthew J. Gilliom 6. (c) Age of husband or wife if alive 74 years  
 7. Birth date of deceased July 10 1876  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Only Aug 2, 1947 to \_\_\_\_\_, 19\_\_\_\_  
 that I last saw her alive on Aug 2, 47, 19\_\_\_\_  
 and that death occurred on the date and hour stated above.

**8. AGE:** Years 71 Months 1 Days 16 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death Senility  
Chronic nephritis

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

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_

10. Usual occupation Housewife

Other conditions None  
(Include pregnancy within 5 months of death)

11. Industry or business \_\_\_\_\_

Major findings: None  
 Of operations \_\_\_\_\_

12. Name Wyle Walls

Of autopsy \_\_\_\_\_

13. Birthplace Madison County Twp.  
(City, town, or county) (State or foreign country)

14. Maiden name Elizabeth Walls

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

16. (a) Informant Matthew J. Gilliom  
 (b) Address Rt. #1 Portageville

17. (a) Burial (b) Date there 8-27-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Madison Mo

18. (a) Signature of funeral director Derfide Funeral Parlor  
 (b) Address Portageville Mo

19. (a) 8-26-47 (b) Ellen Derfide  
(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) (c) Means of injury \_\_\_\_\_

23. Signature A. G. Pender (M. D. or other) **0**

Address Portageville, Mo. Date signed 8/27/47

RECEIVED

District Health Office No. 2,

District File Number 447-1263

Date Filed 9-22-47

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.....

.....  
or Registered Apprentice No.....

working under my personal supervision.

Signed.....

*Not Embalmed*

Licensed Embalmer No.....

P. O. Address.....

**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.