. No. 2
—1/47
5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED JAN 8 1948

Registration District No. 128

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 41399

Primary Registration District No. 2000

Registrar's No. 1098

1. PLACE OF DEATH:
(a) County: Greene
(b) City or town: Springfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Veterans Administration Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 5 months 22 days (Specify whether years, months or days)
In this community: 5 months 22 days

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Greene
(c) City or town: St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No.: 2613 S. 2nd.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country:

3. (a) PRINT FULL NAME: George Murray Jillson
3. (b) If veteran, name war: WW I
3. (c) Social Security No.: 498 09 6344
4. Sex: Male
5. Color or race: White
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: Norma
6. (c) Age of husband or wife if alive: 44 years
7. Birth date of deceased: May (Month) 27 (Day) 1892 (Year)

8. AGE: Years	Months	Days	If less than one day
55	6	20	21 hr. 37 min.

9. Birthplace: Kansas City, Kansas
(City, town, or county) (State or foreign country)
10. Usual occupation: Elevator erector
11. Industry or business:
FATHER 12. Name: Murray Jillson
13. Birthplace: Vermont
(City, town, or county) (State or foreign country)
MOTHER 14. Maiden name: Pauline Nicholson
15. Birthplace: Indiana
(City, town, or county) (State or foreign country)
16. (a) Informant: V.A. records
(b) Address:
17. (a) Removed (Burial, cremation, or removal) (b) Date thereof 12-20-47 (Month) (Day) (Year)
(c) Place: burial or cremation St Louis Mo.
18. (a) Signature of funeral director: Carmen-Schaaf Funeral Home
(b) Address: Springfield, Mo.
19. (a) 12-20-47 (Date received local registrar) (b) M. Handley MD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 18 year 1947 hour 9 minute 37 P.M.
21. I hereby certify that I attended the deceased from June 25, 1947, 19..., to December 18, 1947; that I last saw him alive on December 18, 1947; and that death occurred on the date and hour stated above.

Immediate cause of death: Tuberculosis Far Advanced, Pulmonary	Duration
Due to:	
Due to:	
Other conditions: Bronchiectasis, Tuberculous, Bilateral (Include pregnancy within 3 months of death)	

Major findings:
Of operations: 13 B
Of autopsy: As Above

PHYSICIAN
Underline the cause of 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: Paul O'Leary (M. D. or other) M.D.
Address: O'Reilly VAH, Springfield Mo. Date signed 12/19/47

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

MAR 24 1948

JAN 16 1948

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 L. Dodie Gorman

Licensed Embalmer No. 3177

P. O. Address Springfield, 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.