

No. 2
-12-45
-5-17-39
X47070

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 9733

FILED APR 8 1948

Registration District No. 298

Primary Registration District No. 3054

Registrar's No. 27

1. PLACE OF DEATH:

(a) County Pike
(b) City or town Fleming Mo
(c) Name of hospital or institution Pike County Hospital
(If not in hospital or institution, write street number & location)
(d) Length of stay: In hospital or institution 1 day
Entire Life (Specify whether years, months or days)

3. (a) PRINT FULL NAME BESSIE McILROY

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

4. Sex Fem 5. Color or race W 6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife W T McIlroy 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased: 7 10 1885
(Month) (Day) (Year)

8. AGE: Years 62 Months 7 Days 24 If less than one day hr. _____ min. _____

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name James Madison Duncan
13. Birthplace Pike Co Mo
(City, town, or county) (State or foreign country)

14. Maiden name Bellet
15. Birthplace Pike Co Mo
(City, town, or county) (State or foreign country)

16. (a) Informant W. J. McIlroy
(b) Address Clarksville

17. (a) Burial (b) Date thereof Mar. 5-1948
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Clarksville Mo.

18. (a) Signature of funeral director Norman E. Gosh
(b) Address Salida Mo.

19. (a) Mar 5-1948 (Date received local registrar) Norman E. Gosh (Registrar's signature)
Bessie McIlroy (Licensed Embalmer's Statement on Reverse Side)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Pike 82
(c) City or town Clarksville
(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 3 day 4
year 48 hour 4 minute 55 M.

21. I hereby certify that I attended the deceased from 2-29 48 to 3-4-48, 19____
that I last saw her alive on 3-4-48, 19____
and that death occurred on the date and hour stated above.

Immediate cause of death acute hemorrhagic pancreatitis
Due to _____

Due to _____

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

Major findings: Of operations 830
Of autopsy _____
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?
While at _____ (Specify type of place) _____
(e) Means of injury _____

23. Signature Norman E. Gosh (M. D. or other) _____
Address Clarksville Mo Date signed 3/4/48

DEC 14 1953

71A 35

RECEIVED
District Health Officer No. 10
District File Number 4-48-669
Date Filed APR -7 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 Norman E. Gsoch

Licensed Embalmer No. 2342

P. O. Address Esolia, 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.