

1. PLACE OF DEATH:

(a) County Macon

(b) City or town Macon
(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 _____)

In this community _____ years, months or days

3. (a) PRINT FULL NAME Annabell Gilstrap

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

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

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

7. Birth date of deceased July 16 1869
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>78</u>	<u>10</u>	<u>-</u>	hr. _____ min.

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

10. Usual occupation Housekeeper

11. Industry or business _____

MOTHER FATHER { 12. Name Isaac Walton

13. Birthplace Canada 2
(City, town, or county) (State or foreign country)

14. Maiden name Margaret Humble

15. Birthplace Canada 2
(City, town, or county) (State or foreign country)

16. (a) Informant Harry Gilstrap

(b) Address Macon, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/18/1948
(Month) (Day) (Year)

(c) Place: burial or cremation Callao, Mo.

18. (a) Signature of funeral director Robert S. Keener

(b) Address Macon, Mo.

19. (a) 6/7/48 (Date received local registrar) (b) Paul McNeely (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Macon

(c) City or town Macon
(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 16
year 1948 hour 7:55 minute _____ a.m.

21. I hereby certify that I attended the deceased from 4-16, 1948 to 5-16, 1948
that I last saw her alive on 5-16, 1948
and that death occurred on the date and hour stated above.

Immediate cause of death

Cerebral Hemorrhage Duration 4 days

Due to arterio-sclerosis 15 yrs?

Due to senility

Other conditions Diabetes Fracture mo
(Include pregnancy within 3 months of death)

Major findings: Left side

Of operations _____

Of autopsy 1860

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) _____ 61

(b) Date of occurrence 7-26-48

(c) Where did injury occur? Macon, Mo. and
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home

While at work? no (Specify type of place) (e) Means of injury Fall

23. Signature R. O. P. in D. (M.D. or other) _____

Address Macon, Mo. Date signed 5-19-48

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

070

RECEIVED
District Health Officer No. 10
District File Number 6-48-109
Date Filed JUN 22 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 *Arthur S. Kinn*
Licensed Embalmer No. *78-1*
P. O. Address *Macor md*

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.