

1. PLACE OF DEATH:

(a) County St. Louis Mo.  
(b) City or town St. Louis Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 5335<sup>a</sup> Vernon 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 70 years  
years, months or days

3. (a) PRINT FULL NAME Joseph A. Gilliam

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

4. Sex male Color or race white  
6. (a) Single, widowed, married, divorced, widowed  
6. (b) Name of husband or wife Susan 6. (c) Age of husband or wife if alive deceased  
7. Birth date of deceased Feb. 19, 1855  
(Month) (Day) (Year)

8. AGE: Years 93 Months 3 Days 29 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country) Mo. - U

10. Usual occupation railroad engineer

11. Industry or business retired

12. Name Hordison Gilliam

13. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country) Va. 1

14. Maiden name Susan Burke

15. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country) Va. 1

16. (a) Informant Mr. Floyd Gilliam

(b) Address 204 St. Louis

17. (a) Burial (b) Date thereof 6/21/48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Vahalla Cemetery

18. (a) Signature of funeral director: Jos. A. Howard

(b) Address 1619 26 Grand

19. (a) JUN 21 1948 (b) J.F. Br ed ect  
(Date received from Registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. County no  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 5335<sup>a</sup> Vernon 9  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 18<sup>th</sup>  
year 1948 hour 9:00 minute \_\_\_\_\_ P. M.

21. I hereby certify that I attended the deceased from March 1, 1948 to June 18, 1948  
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia & lower lobe  
Duration 2 days

Due to Thrombosis Cerebral, artery unknown 1 month

Other conditions Arteriosclerosis, generalized

Major findings: 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? \_\_\_\_\_

While at work \_\_\_\_\_ (Specify type of place) \_\_\_\_\_ (a) Manner of injury Berca  
23. Signature Bernard Berca (or other)  
Address 4482 Washington Date signed 20 June '48

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**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.....

*Frank J. Paul*  
Licensed Embalmer No. *2665*  
P. O. Address *St. Louis*

**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.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. Early  
Registrar's No. 5567

Registration District No. 318

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County.....  
(b) City or town St Louis  
(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

Joseph A. Gillian

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

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced wid

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

7. Birth date of deceased Feb 19 (Month) 19 (Day) 19 (Year)

8. AGE: Years 93 Months 3 Days 2 If less than one day, hr. min.

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

10. Usual occupation

11. Industry or business

12. Name.....  
13. Birthplace..... (City, town, or county) (State or foreign country)

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

16. (a) Informant.....  
(b) Address.....

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

(c) Place: burial or cremation.....

13. (a) Signature of funeral director.....

(b) Address.....

19. (a) 6-21-48 (b) J. F. Braddock (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... year 1948 hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 19.....; that I last saw him..... alive on..... 19.....; and that death occurred on the date and hour stated above. Immediate cause of death.....

Duration

Due to.....  
Due to.....

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

Major findings:  
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?

While at work?..... (Specify type of place) (e) Means of injury.....

23. Signature..... (M. D. or other).....

Address..... Date signed.....

SUPPLEMENTARY 8

MOTHER FATHER

S-20885