

FILED JUN 8 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

16341

State File No. \_\_\_\_\_

0362

BIRTH NO. _____		REG. DIST. NO. <u>116</u>		PRIMARY REG. DIST. NO. <u>3020</u>		Registrar's No. <u>82</u>	
1. PLACE OF DEATH a. COUNTY <u>Franklin</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Colorado</u> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Washington</u>		c. LENGTH OF STAY (in this place) <u>3 days</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Colorado Springs</u>			
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>St. Francis Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>2015 N. El Paso Ave</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>ANNA</u>		b. (Middle) <u>BABBARA</u>		c. (Last) <u>GILLASPIE</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>May 29 1950</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED NEVER MARRIED, WIDOWED DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Aug. 20-1877</u>	
9. AGE (In years last birthday) <u>72</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 1 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>		11. BIRTHPLACE (State or foreign country) <u>Highland, Ill</u>		12. CITIZEN OF WHAT COUNTRY <u>US</u>	
13a. FATHER'S NAME <u>Jacob Freuler</u>		13b. MOTHER'S MAIDEN NAME <u>Barbara Mollet</u>		14. NAME OF HUSBAND OR WIFE <u>Roy Gillaspie</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Wm Schlender, Hermann, Mo</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Strangulated Rt. Femoral Hernia</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. <u>Femoral hernia</u>  DUE TO (b) _____  DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Chr. myeloides general</u> <u>10 yrs</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 years</u> <u>5/10/1</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>Omection &amp; descending colon strangulated</u> <u>general</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 28, 1950</u> , to <u>May 29, 1950</u> , that I last saw the deceased alive on <u>May 29, 1950</u> , and that death occurred at <u>5P</u> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Herman H. Schmidt MD</u>				23b. ADDRESS <u>MD &amp; Blw. Washington</u>		23c. DATE SIGNED <u>5-30-50</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>6-1-50</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Highland City Cem.</u>		24d. LOCATION (City, town, or county) (State) <u>Highland, Ill</u>	
DATE REC'D BY LOCAL REG. <u>May 30, 1950</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		FUNERAL DIRECTOR'S SIGNATURE <u>Hugh H. Schum</u>		ADDRESS <u>Hermann, Mo</u>	

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

District File Number  
District Health Officer No. 9,  
RECEIVED  
JUN 3 1950

NOV 26 1952

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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Signed Hugot Blumer

Signed \_\_\_\_\_  
Student Embalmer

Licensed Embalmer No. 3160

P. O. Address Hermann, 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.