

FILED JAN 15 1951

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

41447

State File No. _____

BIRTH NO. _____ REG. DIST. NO. 2 PRIMARY REG. DIST. NO. 4316 Registrar's No. 92

0610
 1

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

1. PLACE OF DEATH a. COUNTY <u>Macon</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Macon</u> <u>0610</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>New Cambria</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>New Cambria</u> <u>0</u>	
c. LENGTH OF STAY (in this place) <u>Life</u>		d. STREET ADDRESS (If rural, give location)	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION			

3. NAME OF DECEASED (Type or Print)	a. (First) <u>John</u>	b. (Middle) <u>Elgin</u>	c. (Last) <u>Gilleland</u>	4. DATE OF DEATH (Month) (Day) (Year)
				<u>Dec.</u> <u>15</u> <u>1950</u>

5. SEX <u>Male</u> <u>0</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Dec. 22, 1863</u>	9. AGE (In years last birthday) <u>86</u>	IF UNDER 1 YEAR Months <u>11</u> Days <u>23</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
-----------------------------	-------------------------------	---	---------------------------------------	---	---	---

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Proprietor</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Retail Furniture</u>	11. BIRTHPLACE (State or foreign country) <u>New Cambria, Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
---	---	---	--

13a. FATHER'S NAME <u>John Wesley Gilleland</u>	13b. MOTHER'S MAIDEN NAME <u>Margaret Jobson</u>	14. NAME OF HUSBAND OR WIFE <u>Linnie Gilleland</u>
---	--	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No.</u>	16. SOCIAL SECURITY NO. <u>XXXX</u>	17. INFORMANT'S SIGNATURE OR NAME <u>H.J. Gilleland, New Cambria, Mo.</u>	ADDRESS
---	-------------------------------------	---	---------

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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>4 mo</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Old Age Infirmitie</u>		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	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) (Min.)	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 Sept, 1945, to Dec, 1950, that I last saw the deceased alive on Dec 15, 1950, and that death occurred at 7:05p m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Howest</u>	23b. ADDRESS <u>M. So New Cambria Mo</u>	23c. DATE SIGNED <u>Dec 18 50</u>
--	--	-----------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Dec. 18, 1950</u>	24c. NAME OF CEMETERY OR CREMATORY <u>New Cambria</u>	24d. LOCATION (City, town, or county) (State) <u>New Cambria, Mo.</u>
---	--------------------------------	---	---

DATE REC'D BY LOCAL REG. <u>12/28/50</u>	REGISTRAR'S SIGNATURE <u>Josephine King</u> <u>399</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>H.J. Gilleland</u>	ADDRESS <u>New Cambria Mo</u>
--	--	--	-------------------------------

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

1. 10. 51

MACON COUNTY HEALTH DEPARTMENT

County File No. 1. 51. 253 3

Date Filed 1. 11. 51

~~Date Received: JAN 7 1951
DISTRICT HEALTH OFFICE #2
District File Number
Date Filed:~~

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.

Student _____
Student Embalmer

Signed J. B. Blacklock
Licensed Embalmer No. 2246

P. O. Address Beaufield 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.