

FILED JAN 15 1951

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 572

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 72 PRIMARY REG. DIST. NO. 4134 Registrar's No. 2

1. PLACE OF DEATH a. COUNTY CLAY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY CLAY	
b. CITY (If outside corporate limits, write RURAL and give township) SMITHVILLE		c. CITY (If outside corporate limits, write RURAL and give township) SMITHVILLE	
c. LENGTH OF STAY (in this place) 4 MONTHS		d. STREET ADDRESS (If rural, give location) NONE	
d. FULL NAME OF HOSPITAL OR INSTITUTION NONE			

3. NAME OF DECEASED a. (First) MAE b. (Middle) GILLESPIE c. (Last) GILLESPIE			4. DATE OF DEATH (Month) (Day) (Year) JAN. 2 1951		
5. SEX fe /	6. COLOR OR RACE WH	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED /	8. DATE OF BIRTH MAY 19, 1874	9. AGE (In years last birthday) 76	IF UNDER 1 YEAR Months 7 Days 14
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	11. BIRTHPLACE (State or foreign country) MISSOURI		12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME HARVEY ANDERSON	13b. MOTHER'S MAIDEN NAME SALLY KURTRIGHT	14. NAME OF HUSBAND OR WIFE JOHN GILLESPIE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. NONE	17. INFORMANT'S SIGNATURE OR NAME MRS. OPAL MAXWELL	ADDRESS TONGANOXIE, KANSAS
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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, asthma, etc. It means the disease, injury, or complication which caused death.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral vascular hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH <u>17 hrs</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Hypertension severe + Hypertensive vascular disease</u>		
	DUE TO (c) 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"/>
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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 12-7, 1950, to 1-2, 1951, that I last saw the deceased alive on 1-2, 1951, and that death occurred at 3:05 AM., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>M.D.</u>	23b. ADDRESS <u>Smithville, Mo.</u>	23c. DATE SIGNED <u>1-2-51</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 1-3-51	24c. NAME OF CEMETERY OR CREMATORY GRANDVIEW CEMETERY	24d. LOCATION (City, town, or county) (State) ALBANY MISSOURI
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DATE REC'D BY LOCAL REG. <u>Jan 3-51</u>	REGISTRAR'S SIGNATURE <u>Beulah Kitchener</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS MCCOMAS FUNERAL HOME SMITHVILLE, MO.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD



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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 \_\_\_\_\_

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

working under my personal supervision.

Student .....  
Student Embalmer

Signed \_\_\_\_\_

*Donald W. Hauke*

Licensed Embalmer No. *4528*

P. O. Address *Smithville, 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.