

FILED DEC 22 1952

THE DIVISION OF HEALTH OF MISSOURI STANDARD CERTIFICATE OF DEATH

State File No. **42813**

BIRTH NO. _____ REG. DIST. NO. **198** PRIMARY REG. DIST. NO. **4311** Registrar's No. **166**

1. PLACE OF DEATH a. COUNTY Macon		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY Macon	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Callao		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Callao 0610	
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If rural, give location) 0	

3. NAME OF DECEASED (Type or Print) a. (First) DEMON b. (Middle) HAMPTON c. (Last) GILSTROP			4. DATE OF DEATH (Month) (Day) (Year) 12-3-52		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 2-26-79	9. AGE (In years last birthday) 73	IF UNDER 1 YEAR Months Days IF UNDER 4 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Mo		12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME B. N. Silstrop	13b. MOTHER'S MAIDEN NAME Martha Wright	14. NAME OF HUSBAND OR WIFE Joie Gilstrop
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Joie Gilstrop, Callao Mo

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.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 6 days unknown unknown
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Apoplexy		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertension DUE TO (c) Arteriosclerosis		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 334X	20. AUTOPSY? YES <input type="checkbox"/> NO <input 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 **Nov. 28, 1952**, to **Dec 3, 1952**, that I last saw the deceased alive on **Dec 3, 1952**, and that death occurred at **7 P. m.**, from the causes and on the date stated above.

23a. SIGNATURE C. L. Dickerson (Degree of title)	23b. ADDRESS Macon	23c. DATE SIGNED 12/8/52
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 12-5-52	24c. NAME OF CEMETERY OR CREMATORY Locust Grove Cem.	24d. LOCATION (City, town, or county) (State) Callao Mo
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DATE REC'D BY LOCAL REG. 12-9-52	REGISTRAR'S SIGNATURE Josephine King	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS W. S. Edwards, Berwin Mo
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED 12.17.52
MACON COUNTY HEALTH DEPARTMENT
County File No. 12.52.128
Date Filed 12.18.52

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. G. Edwards*

Licensed Embalmer No. 1961

P. O. Address *Berwin, 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.