

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **1437**
REG. DIST. NO. **149** PRIMARY REG. DIST. NO. **1002** Registrar's F.No. **93**FILED FEB 9 1953
BIRTH NO. _____

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY JACKSON	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN KANSAS CITY		c. LENGTH OF STAY (In this place) 6 YRS.	
d. FULL NAME OF HOSPITAL OR INSTITUTION 4036 WABASH		d. STREET ADDRESS (If rural, give location) 4036 WABASH	
3. NAME OF DECEASED (Type or Print) VIOLA CATHERINE		c. (Last) GILLILAN	
a. (First)		b. (Middle)	
4. DATE OF DEATH (Month) (Day) (Year) JAN. 6 1953		5. SEX FEMALE	
6. COLOR OR RACE WHITE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	
8. DATE OF BIRTH 15 OCT. 1865		9. AGE (In years last birthday) Months Days 87	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE	
11. BIRTHPLACE (City and State or Foreign Country) JAMESPORT, MISSOURI		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME NOAH CRODERAN		13b. MOTHER'S MAIDEN NAME ELIZABETH STILES	
14. NAME OF HUSBAND OR WIFE SAM GILLILAN		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. X X X X X X X X		17. INFORMANT'S SIGNATURE OR NAME FRANK J. GILLILAN	
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Senility. ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Coronary Vascular disease, chronic. DUE TO (c) Sclerosis II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION None		19b. MAJOR FINDINGS OF OPERATION None	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT SUICIDE HOMICIDE (Specify) none	
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) m. _____		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 Jan 5th , 19 53 , to Jan 6th , 19 53 , that I last saw the deceased alive on Jan 6th , 19 53 , and that death occurred at _____ m., from the causes and on the date stated above.	
23a. SIGNATURE Frank J. Gillilan M.D. MD		23b. ADDRESS 807 Argyle Bldg.	
23c. DATE SIGNED Jan 8-53		24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	
24b. DATE 9 JAN-53		24c. NAME OF CEMETERY OR CREMATORY FLORAL HILLS	
24d. LOCATION (City, town, or county) (State) KANSAS CITY, MO.		DATE REC'D BY LOCAL REG. 1-9-53	
REGISTRAR'S SIGNATURE Geraldine Smith		25. FUNERAL DIRECTOR'S SIGNATURE FLORAL HILLS MEMORIAL CHAPELS K.C.	
ADDRESS FLORAL HILLS MEMORIAL CHAPELS K.C.		MO.	

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 *Loyal C. McCord*

Licensed Embalmer No. *4853*

P. O. Address *H. C. 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.