

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

42086

State File No.

11541

FILED JAN 17 1956

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips Hospital		STREET ADDRESS (If rural, give location) 3045 Thomas	

3. NAME OF DECEASED (Type or Print)	a. (First) Leola	b. (Middle)	c. (Last) Gillispie	4. DATE OF DEATH (Month) (Day) (Year)
				12 29 55

5. SEX F	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH Jan. 10, 1924	9. AGE (In years last birthday) 31	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Day Work	10b. KIND OF BUSINESS OR INDUSTRY Dist. Ameliora Newton	11. BIRTHPLACE (City and State or Foreign Country) Shreveport, Louisiana	12. CITIZEN OF WHAT COUNTRY?
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13a. FATHER'S NAME Walter Chapman	13b. FATHER'S MAIDEN NAME Ina Palmer	14. NAME OF HUSBAND OR WIFE John Lee Gillispie
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Robert Chapman 3045 Thomas	ADDRESS
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Eclampsia		Undt.
	ANTECEDENT CAUSES DUE TO (b) Term Pregnancy Undelivered		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.		Hypertension (Pre-existing)	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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)
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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?
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22. I hereby certify that I attended the deceased from **12-27**, 19**55**, to **12-29**, 19**55**, that I last saw the deceased alive on **12-29**, 19**55**, and that death occurred at **10:45a** m., from the causes and on the date stated above.

23a. SIGNATURE William L. Smiley	(Degree or title) M.D.	23b. ADDRESS 2601 N. Whittier	23c. DATE SIGNED 12-30-55
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24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE Dec 31, 1955	24c. NAME OF CEMETERY OR CREMATORY Meridian, Mississippi	24d. LOCATION (City, town, or county) (State)
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DATE RECD BY LOCAL REG. DEC 30 1955	REGISTRAR'S SIGNATURE Carl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE E. B. Lauce	ADDRESS 1221 N. 5th
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(Licensed Embalmer's Statement on Reverse Side)

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

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.....
Signature of Student Embalmer

Signed *Malvin Blackman*.....

Licensed Embalmer No. *396*

P. O. Address *1271 W*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.