

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-010615

APR 15 1959

STATE FILE NUMBER

Registration District No. 316 Primary Registration District No. 3059 Registrar's No. 130

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| 1. PLACE OF DEATH a. COUNTY <u>St. Francis</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Washington</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Bonne Terre</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN <u>1100</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Bonne Terre Hosp.</u> | | Length of stay in 1b <u>2 weeks</u> | d. STREET ADDRESS (If outside, give location) <u>1 mi. E. Belgrade</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print) First <u>E. Inez</u> Middle <u>a</u> Last <u>Gilliam</u> | | | 4. DATE OF DEATH Month <u>April</u> Day <u>3</u> Year <u>1959</u> | | |
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| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Aug. 26 1890</u> | 9. AGE (In years last birthday) <u>68</u> IF UNDER 1 YEAR Months <u>7</u> Days <u>7</u> IF UNDER 24 HRS. Hours <u>7</u> Min. <u>7</u> |
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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Railroading</u> | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) <u>Washington Co. Mo U.S.A.</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
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| 13a. FATHER'S NAME <u>James Gilliam</u> | 13b. MOTHER'S MAIDEN NAME <u>Fannie Young</u> | 14. NAME OF HUSBAND OR WIFE <u>Blanche Gilliam</u> |
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| 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. IF INFORMANT <u>Blanche Gilliam Belgrade Mo.</u> |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral embolus</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) <u>Myocardial infarction/</u> | <u>3 weeks</u> |
| | DUE TO (c) <u>Arteriosclerotic coronary thrombosis.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4201</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |

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| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) |
| 20c. TIME OF INJURY Hour <u>6:00</u> Month, Day, Year | |

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| 20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 20f. CITY, TOWN, OR LOCATION <u>Bonne Terre, Mo.</u> | COUNTY <u>Washington Co.</u> | STATE <u>Mo.</u> |
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| 21. I attended the deceased from <u>Mar. 21, 1959</u> to <u>Apr. 3, 1959</u> and last saw <u>her</u> alive on <u>Apr. 3, 1959</u> Death occurred at <u>6:00</u> <u>am</u> on the date stated above; and to the best of my knowledge, from the causes stated. | |
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| 22a. SIGNATURE <u>Robert W. Fuller M.D.</u> | (Degree or title) <u>M.D.</u> | 22b. ADDRESS <u>Bonne Terre, Mo.</u> | 22c. DATE SIGNED <u>4/7/59</u> |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>4-5-59</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Caledonia M.E. Cem.</u> | 23d. LOCATION (City, town, or county) <u>Washington Co. Mo.</u> | (State) |
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| 24. FUNERAL DIRECTOR <u>Mrs. Lutha Sparks Peters</u> | ADDRESS <u>Mo. Apr. 8, 1959</u> | 25. DATE RECD. BY LOCAL REG. | 26. REGISTRAR'S SIGNATURE <u>Ether Rudloff</u> |
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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 *Murphy L. Sparks*

Licensed Embalmer No. *4236*

P. O. Address... *Flat River*

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.