

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH 28 59-020801

FILED JUL 7 1959 88

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STATE FILE NUMBER

Registration District No. Primary Registration District No. Registrar's No.

|   |  |   |  |   |   |   |   |  |       |  |  |  |  |
|---|--|---|--|---|---|---|---|--|-------|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Crawford</b>  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>Crawford</b>                 |   |   |   |  |       |  |  |  |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>OSAGE</b>   |  | Length of stay in lb <b>2 yr.</b>   |  | c. CITY OR TOWN <b>Cherryville</b>  |   | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |   |  |       |  |  |  |  |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>12 mi. S. of steelville</b>  |  |   | Inside Limits<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |   | d. STREET ADDRESS (If outside, give location) |   | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |  |       |  |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Ford</b> Middle <b>William</b> Last <b>Gillison</b>   |  |   |  | 4. DATE OF DEATH<br>Month <b>6</b> Day <b>29</b> Year <b>59</b>   |   |   |   |  |       |  |  |  |  |
| 5. SEX <b>Male</b>  |  | 6. COLOR OR RACE <b>White</b>   |  | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> |   | 8. DATE OF BIRTH <b>9-27-90</b>   |   | 9. AGE (last birthday) <b>68</b>   |       | IF UNDER 1 YEAR<br>Months <b>9</b> Days <b>2</b> |  | IF UNDER 24 HR<br>Hours <b></b> Min. <b></b> |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Railroad CAR Inspector</b>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY   |   | 11. BIRTHPLACE (City and state or country)<br><b>Echerty, INDIANA</b>     |   | 12. CITIZEN OF WHAT COUNTRY<br><b>U. S. A.</b>   |       |  |  |  |  |
| 13a. FATHER'S NAME<br><b>James Gillison</b>   |  |   |  | 13b. MOTHER'S MAIDEN NAME<br><b>Docia Westerfield</b>   |   |   |   | 14. NAME OF HUSBAND OR WIFE<br><b>Rosella MAE</b>  |       |  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>NO</b>   |  |   |  | 16. SOCIAL SECURITY NO.<br><b>704-18-5570</b>   |   | 17. INFORMANT Address<br><b>Mrs. F. Gillison Cherryville, Mo.</b>         |   |  |       |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b>  |  |   |  |   |   |   |   |  |       | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 hrs</b> |  |  |  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____  |  |   |  |   |   |   |   |  |       |  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><b>Diabetes Mellitus</b> <b>Essential Hypertension</b>   |  |   |  |   |   |   |   | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |       |  |  |  |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 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<br>Hour _____ a.m. _____ p.m.   |  | Month, Day, Year _____  |  |   |   |   |   |  |       |  |  |  |  |
| 20d. INJURY OCCURRED WHILE AT WORK <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                  |   | COUNTY  |  | STATE |  |  |  |  |
| 21. I attended the deceased from <b>6-28-56</b> to <b>6-29-59</b> and last saw him alive on <b>6-29-59</b><br>Death occurred at <b>1:40</b> p.m. on the date stated above, and to the best of my knowledge, from the causes stated. |  |   |  |   |   |   |   |  |       |  |  |  |  |
| 22a. SIGNATURE (Degree or title)<br><b>Abraham M.D.</b>   |  |   |  | 22b. ADDRESS<br><b>Steelville, Mo</b>   |   |   |   | 22c. DATE SIGNED<br><b>7-1-59</b>  |       |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>7-2-59</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cherryville</b>  |   |   |   | 23d. LOCATION (City, town, or county) (State)<br><b>Crawford Mo.</b>   |       |  |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Harry Jonas steelville</b>   |  |   |  | ADDRESS   |   | 25. DATE RECD. BY LOCAL REG.<br><b>7-5-59</b>                             |   | 26. REGISTRAR'S SIGNATURE<br><b>Mrs. Hazel Schies</b>  |       |  |  |  |  |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_ or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed \_\_\_\_\_

Licensed Embalmer No. 2628

P. O. Address Steelville

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.