

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-027924

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Registration District No. _____ Primary Registration District No. 6225 Registrar's No. 129

STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY <u>Washington Vernon</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Wright</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Washington</u>		Length of stay in 1b <u>14 days</u>		c. CITY OR TOWN <u>Norwood Missouri</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>State Hospital #3</u>				Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Floyd</u> Middle <u>Gilley</u> Last <u>(gilly)</u>			4. DATE OF DEATH Month <u>July</u> Day <u>30</u> Year <u>1959</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</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>Sept 17, 1879</u>	9. AGE (last birthday) <u>79</u>	IF UNDER 1 YEAR Months <u>11</u> Days <u>6</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (City and state or country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13a. FATHER'S NAME <u>John Ransom Gilly</u>			13b. MOTHER'S MAIDEN NAME <u>Rebecca Russell</u>			14. NAME OF HUSBAND OR WIFE <u>Mandy Gilly</u>	
15. WAS DECEASED EVER IN ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unk</u>			16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>Records State Hospital #3</u>		
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>Bronchial pneumonia</u>						INTERVAL BETWEEN ONSET AND DEATH <u>several days</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>general arterio-sclerosis</u>						<u>several years</u>	
DUE TO (c) <u>Chronic Brain Syndrome with Cerebral Arteriosclerosis</u>						<u>several years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (If terminal disease condition given in PART I (a)) <u>hypertension</u>						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> <u>NONE</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)				
20c. TIME OF INJURY 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 <u>July 16, 1959</u> to <u>July 30, 1959</u> and last saw him alive on <u>July 30, 1959</u> Death occurred at <u>9:15 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Leslie H. Wright M.D.</u>				22b. ADDRESS <u>State Hospital #3 Nevada Mo</u>		22c. DATE SIGNED <u>July 30 59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>July 31, 59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>City Cemetery</u>		23d. LOCATION (City, town, or county) <u>Mountain Grove, Missouri</u>		(State)
24. FUNERAL DIRECTOR <u>Barber Funeral Home Mountain Grove, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>8-8-1959</u>		26. REGISTRAR'S SIGNATURE <u>Arma & Ferris</u>		

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 R Percy F. Milster

Licensed Embalmer No. 4805

P. O. Address Nevada, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.