

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JAN 10 1961

-61-001856

STATE FILE NUMBER

AMENDED

Registration District No. 156 Primary Registration District No. 2001 Registrar's No. 9

1. PLACE OF DEATH a. COUNTY <u>Jasper</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Newton</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Joplin</u>		Length of stay in 1b <u>6 wks.</u>	c. CITY OR TOWN <u>Racine</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. John's Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input 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>Eva</u> Middle <u>Gilstrap</u> Last <u>Gilstrap</u>			4. DATE OF DEATH Month <u>Jan.</u> Day <u>1</u> Year <u>1961</u>		
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5. SEX <u>Fem.</u>	6. COLOR OR RACE <u>wht.</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 22 1906</u>	9. AGE (last birthday) <u>54</u>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (City and state or country) <u>Newton Co. Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>W.C. Coy</u>	13b. MOTHER'S MAIDEN NAME <u>Della Morehead</u>	14. NAME OF HUSBAND OR WIFE <u>Maynard Lee Gilstrap</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, go, or unknown)   (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. -----	17. INFORMANT <u>Virgil Gilstrap, Racine, Mo.</u>	Address
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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>Hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 h</u> <u>4 MO</u> <u>Unknown</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Carcinomatosis</u>	
	DUE TO (c) <u>Cervical ca</u>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		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
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year
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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 _____
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21. I attended the deceased from Jan 1960 to Jan 1961 and last saw her alive on 1-1-61  
Death occurred at 8:50 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>W.A. Wilcox MD</u>	(Degree or title)	22b. ADDRESS <u>1923 Sargent</u>	22c. DATE SIGNED <u>1-2-61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Jan. 4, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Burkhart Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Racine, Missouri</u>
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24. FUNERAL DIRECTOR <u>W. E. Blum</u>	ADDRESS <u>Seneca MO</u>	25. DATE RECD. BY LOCAL REG. <u>Jan. 6 - 1961</u>	26. REGISTRAR'S SIGNATURE <u>Dove Merriam</u>
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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

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 me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

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

Signed

*W. B. Bedderson*

Licensed Embalmer No.

*2174*

P. O. Address

*Seneca*

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.