

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-008094

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **2687**

DO NOT WRITE ON THIS STUB

AMENDED

FILED MAR 15 1962

VS 300
Rev. 4/59

1

28120-71

3

4 0

5 1

6

7 1

8 1

9

10

11

1252-0

13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

SHOULD READ

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		Length of stay in lb		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE ILL. b. COUNTY TAZEWELL		c. CITY OR TOWN TREMONT, ILL.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS NONE.				Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle R. Last GILLMORE						4. DATE OF DEATH Month MARCH Day 8 Year 1962					
5. SEX MALE.		6. COLOR OR RACE WHITE.		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 8-18-1895		9. AGE (last birthday) 66		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER				10b. KIND OF BUSINESS OR INDUSTRY STERPILLAR, TREATOR. CO.		11. BIRTHPLACE (City and state or country) FORREST CITY, ILL.		12. CITIZEN OF WHAT COUNTRY U.S.A.			
13a. FATHER'S NAME ARTHUR GILLMORE.				13b. MOTHER'S MAIDEN NAME MINNIE STEWART.				14. NAME OF HUSBAND OR WIFE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) WAR I.						16. SOCIAL SECURITY NO.		17. INFORMANT MRS ALMA GILLMORE.		Address TREMONT, ILL.	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY:										INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA										2 WEEKS	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.											
DUE TO (b) PULMONARY EMPHYSEMA										5 YEARS	
DUE TO (c) 527.1											
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 type="checkbox"/> No <input type="checkbox"/> Unknown	
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.)							
20c. TIME OF INJURY Hour <input type="checkbox"/> Month, Day, Year <input type="checkbox"/> s.m. p.m.											
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 SEPT. 5, 1960 to MARCH 8, 1962 and last saw her/him alive on MARCH 8, 1962						Death occurred at 4:30 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>C. O. Vermillion, M.D.</i>				(Degree or title)		22b. ADDRESS BARNES HOSPITAL		22c. DATE SIGNED 3/9/62			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City, town, or county) (State)			
Burial		3/12/62		Glendale Memorial Pt 9 Cedar Ill							
24. FUNERAL DIRECTOR <i>W. H. Davis</i>				ADDRESS Tremont, Ill		25. DATE RECD. BY LOCAL REG. MAR 9 1962		26. REGISTRAR'S SIGNATURE <i>Loan Smith, M.D.</i>			

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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.