

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-017652

STATE FILE NUMBER

Registration District No. 324 Primary Registration District No. 30720 Registrar's No. 87

FILED MAY 1 1962						
1. PLACE OF DEATH						
a. COUNTY <u>Saline</u>						
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Marshall</u> Length of stay in lb <u>3 months</u>						
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Fitzgibbon hospital</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>						
2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)						
a. STATE <u>Missouri</u> COUNTY <u>Saline</u>						
c. CITY OR TOWN <u>Nelson</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>						
d. STREET ADDRESS (If outside, give location) <u>Route No. 2</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>						
3. NAME OF DECEASED			4. DATE OF DEATH			
First <u>Margaret</u> Middle <u>Elizabeth</u> Last <u>Gillespie</u>			Month <u>April</u> Day <u>25th</u> Year <u>1962</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</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>2-13-1868</u>	9. AGE (last birthday) <u>94</u>	IF UNDER 1 YEAR	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	11. BIRTHPLACE (City and state or country) <u>Pettis County, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>		
13a. FATHER'S NAME <u>James Carroll</u>		13b. MOTHER'S MAIDEN NAME <u>Cordelia Belle Renault</u>		14. NAME OF HUSBAND OR WIFE <u>Thomas A. Gillespie</u>		
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. <u>[REDACTED]</u>	17. INFORMANT <u>Route No. 2</u> Address <u>Miss Loretta Gillespie, Nelson, Mo.</u>			
18. CAUSE OF DEATH (Enter only one cause per line)						
PART I. DEATH WAS CAUSED BY:						
IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u>						
DUE TO (b) <u>Arteriosclerosis</u>						
DUE TO (c) _____						
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 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 _____	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 _____		STATE _____
21. I attended the deceased from <u>1-4-62</u> to <u>4-25-62</u> and last saw her alive on <u>4-25-62</u>						
Death occurred at <u>10-30 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>MD</u>		22b. ADDRESS <u>Marshall Mo.</u>		22c. DATE SIGNED <u>4-25-62</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>4-28-1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Nelson cemetery</u>		23d. LOCATION (City, town, or county) <u>Nelson Missouri</u> (State)	
24. FUNERAL DIRECTOR <u>Campbell-Lewis, Marshall, Mo.</u> ADDRESS _____		25. DATE RECD. BY LOCAL REG. <u>April 26-62</u>		26. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

DO NOT WRITE ON THIS STUB

AMENDED

VS 300 Rev. 4/59

1 0975

2 0970

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9 331X

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

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

R. W. Campbell Jr.

Licensed Embalmer No.

3469

P. O. Address

Marshall, 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.