

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-037639

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 615

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED NOV 5 1962

1. PLACE OF DEATH a. COUNTY <u>BOONE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>LAFAYETTE</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u>		c. CITY OR TOWN <u>Otessa</u>	
Length of stay in lb <u>16 days</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>University of Mo. Medical Center</u>		d. STREET ADDRESS (If outside, give location) <u>412 S 4th.</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>PAUL</u> Middle <u>Glennon</u> Last <u>Gilmer</u>			4. DATE OF DEATH Month <u>10</u> Day <u>27</u> Year <u>62</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>white</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>7 7 11</u>	9. AGE (last birthday) <u>51</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>meat cutter</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Auxvasse, Mo</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S</u>
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13a. FATHER'S NAME <u>William E. Gilmer</u>	13b. MOTHER'S MAIDEN NAME <u>Sadie O'Brien</u>	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	17. INFORMANT <u>Medical Records Columbia, Mo</u>	Address <u>Columbia, Mo</u>
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18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Ascending Cholangitis</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
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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"/>	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 <u> </u> a.m. <u> </u> p.m. <u> </u> Month, Day, Year <u> </u> <u> </u> <u> </u>

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 <u>Columbia, Mo</u>	COUNTY <u> </u> STATE <u> </u>
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21. I attended the deceased from 9:30 Oct 10-62 to Death and last saw him alive on 10-27-62
Death occurred at 9:30 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Earl Russell MD</u>	(Degree or title)	22b. ADDRESS <u>2111 McC Columbia, Mo</u>	22c. DATE SIGNED <u>10-27-62</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>10/27/1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St Brendon's Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>Mexico, Mo</u>
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24. FUNERAL DIRECTOR <u>Arnold Funeral Home, Mexico, Mo.</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>Oct 27 1962</u>	26. REGISTRAR'S SIGNATURE <u>Mrs R.E. Palmer</u>
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(Licensed Embalmer's Statement on Reverse Side)

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

NOV 14 1962

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 Harrold E. Hayes

Licensed Embalmer No. 4890

P. O. Address Manice 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.