

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-043595

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

FILED DEC 4 1962

Primary Registration District No.

Registrar's No.

50

VS 300
Rev. 4/59

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

1. PLACE OF DEATH a. COUNTY <u>Ozark</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Ozark</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Gainesville</u>		c. CITY OR TOWN <u>Gainesville</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Home</u>		d. STREET ADDRESS (If outside, give location) <u>Third Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Otis</u> Last <u>Gilliland</u>		4. DATE OF DEATH Month <u>11</u> Day <u>26</u> Year <u>1962</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐	8. DATE OF BIRTH <u>9-8-1894</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>County Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>County</u>	
11a. FATHER'S NAME <u>Robert G. Gilliland</u>		11b. MOTHER'S MAIDEN NAME <u>Josephine Forrest</u>	
12a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		12b. SOCIAL SECURITY NO. <u>500-34-6431A</u>	
13. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Cardiac Failure</u>		3 days	
DUE TO (c) <u>Arteriosclerotic heart disease</u>		3-4 yrs.	
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. ☐ Yes ☐ No ☐ Unknown	
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <u>1:45</u> a.m. <u>pm</u> Month, Day, Year <u>12-6-1958</u>			
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐		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>12-6-1958</u> to <u>11-26-62</u> and last saw her alive on <u>11-26-62</u>			
Death occurred at <u>1:45 pm</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Arthur L. Beard</u>		22b. ADDRESS <u>Gainesville, Mo</u>	
22c. DATE SIGNED <u>11-26-62</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>11-28-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Gainesville City</u>		23d. LOCATION (City, town, or county) <u>Gainesville</u> (State) <u>Mo</u>	
24. FUNERAL DIRECTOR <u>Clinkingbeard, Gainesville, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>12-1-62</u>	
26. REGISTRAR'S SIGNATURE <u>Barbara Shaw</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

John R. Lurvey

Licensed Embalmer No. 4885

P. O. Address Cambridge, 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.