

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

Do not use this space.

40424

**1. PLACE OF DEATH**

County Haney  
Township Shelburne field  
City \_\_\_\_\_ (No. \_\_\_\_\_)

Registration District No. 349  
Primary Registration District No. 5580

File No. \_\_\_\_\_  
Registered No. 5  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

William Lewis Gillespie  
(a) Residence. No. Clinton R 8 St. \_\_\_\_\_ Ward \_\_\_\_\_

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 11 - 1872

7. AGE 57 YEARS MONTHS 25 DAYS 24 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Farmer  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
(c) Name of employer \_\_\_\_\_

**9. BIRTHPLACE (CITY OR TOWN)**

(STATE OR COUNTRY) Kansas

10. NAME OF FATHER J R Gillespie

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Ohio

12. MAIDEN NAME OF MOTHER not know

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) not know

14. INFORMANT Mrs. Russell  
(Address) \_\_\_\_\_

15. FILED Jan 13 1930 Mrs. A. D. Gray REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 5 1929

17. I HEREBY CERTIFY, That I attended deceased from Apr 18 1929 to Dec 4 1929 that I last saw him alive on Dec 25 1929, and that death occurred, on the date stated above, at 5 am m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Diabetic Mellitus  
Chronic Myocarditis  
and Influenza  
(duration) 3 yrs. mos. ds.  
CONTRIBUTORY (SECONDARY) and Influenza  
(duration) \_\_\_\_\_ yrs. mos. ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH. not known

DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS Clinical diagnosis  
(Signed) Chas. S. Searcy M. D.  
, 19 \_\_\_\_\_ (Address) Calhoun Mo

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL St Olive DATE OF BURIAL Dec 7 1929

20. UNDERTAKER J A Housey ADDRESS Calhoun Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

