

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

PLACE OF DEATH New Madrid  
County New Madrid  
Township Atchafalaya Registration District No. 603 File No. 25378  
or  
Village \_\_\_\_\_ Primary Registration District No. 4257 Registered No. 19  
or City Morehouse (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)  
FULL NAME Bert Gilligan

(If death occurred in a hospital or institution, give its NAME instead of street and number)

PERSONAL AND STATISTICAL PARTICULARS

1 MEDICAL CERTIFICATE OF DEATH

SEX <u>Male</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>Married</u>
DATE OF BIRTH <u>May 31</u> , 1 <u>894</u> (Month) (Day) (Year)		
AGE <u>21</u> yrs. <u>2</u> mos. <u>16</u> ds.		IF LESS than 1 day, _____ hrs. or _____ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>Laborer</u> (b) General nature of industry, business, or establishment in which employed (or employer)		
BIRTHPLACE (City or town, State or foreign country) <u>Golden Pond Ky</u>		
PARENTS	NAME OF FATHER <u>Heber J. Gilligan</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Golden Pond Ky</u>	
	MAIDEN NAME OF MOTHER <u>Luie Ferguson</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Golden Pond Ky</u>	
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>R. J. Gilligan</u> (ADDRESS) <u>Morehouse Mo</u>		

DATE OF DEATH Aug 16, 1915  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Aug 16, 1915, to \_\_\_\_\_, 1915, that I last saw him alive on Aug 16, 1915, and that death occurred, on the date stated above, at 7-42 am.

The CAUSE OF DEATH was as follows:  
Gun Shot wound

173  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory (SECONDARY)? \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) J. J. [Signature] M. D.  
8-16-1915 (Address) Morehouse Mo

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)  
At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted if not at place of death? \_\_\_\_\_  
Former or usual residence \_\_\_\_\_

PLACE OF BURIAL OR REMOVAL Sebastian Mo. DATE OF BURIAL 8-17-1915

UNDERTAKER Marshall [Signature] Mo. ADDRESS Morehouse Mo

Filed 8-16, 1915 by R. J. [Signature] REGISTRAR

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.

# Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health  
Association]

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Colton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return: "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid

use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "*Asithenia*," "*Anaemia*" (merely symptomatic), "*Atrophy*," "*Collapse*," "*Coma*," "*Convulsions*," "*Debility*" ("*Congenital*," "*Senile*," etc.), "*Dropsy*," "*Exhaustion*," "*Heart failure*," "*Haemorrhage*," "*Inanition*," "*Marasmus*," "*Old age*," "*Shock*," "*Uraemia*," "*Weakness*," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "*PUERPERAL septicaemia*," "*PUERPERAL peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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CERTIFICATE OF DEATH

1 PLACE OF DEATH  
*New Madrid*  
County

REGISTRARS SHALL NOT RECEIVE  
A FEE FOR CERTIFICATES UNTIL THEY  
ARE COMPLETED AS PRESCRIBED BY  
LAW

Township  
or  
Village  
or  
City

Registration District No. *603* File No. ....  
Primary Registration District No. *4357* Registered No. *19*  
St. .... Ward)

If death occurred in a  
hospital or institution,  
give its NAME instead  
of street and number.

2 FULL NAME *Bert Gillihan*

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <i>M</i>	4 COLOR OR RACE <i>W.</i>	5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <i>M</i>
6 DATE OF BIRTH <i>Satisfactory Information Supplied</i> (Month) (Day) (Year)		
7 AGE <i>Satisfactory Information Supplied</i> yrs. mos. ds.		If LESS than 1 day... hrs. or... min.?
8 OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry business, or establishment in which employed (or employer)		
9 BIRTHPLACE (City or town, State or foreign country)		
PARENTS	10 NAME OF FATHER	
	11 BIRTHPLACE OF FATHER (City or town, State or foreign country)	
	12 MAIDEN NAME OF MOTHER	
	13 BIRTHPLACE OF MOTHER (City or town, State or foreign country)	

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH  
*Aug. 16* 191*5*  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from  
191... to 191...  
that I last saw h... alive on... 191...  
and that death occurred, on the date stated above... m.  
The CAUSE OF DEATH was as follows:  
*Gun Shot Wound*  
*Homicide*  
*182*  
CONTRIBUTORY  
(Secondary)  
(Duration) yrs. mos. ds.  
(Signed) *W. B. Miller M.D.*  
*8/16/15* (Address) *Warehouse*

\*State the Disease Causing Death, or, in death from Violent Causes, state  
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)  
At place of death... yrs. mos. ds. In the State... yrs. mos. ds.  
Where was disease contracted if not at place of death?  
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL  
191...

20 UNDERTAKER ADDRESS  
*Marshall Keenan, New O.* *Warehouse, Mo.*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) *Satisfactory Information Supplied*  
(Address) *Satisfactory Information Supplied*

15 Filed *Aug 16, 1915* *John J. Powers*  
Registrar

Original file, date *AUG 20 1915*

All information called for must be written on this Supplementary Certificate.

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*Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc.* of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatio), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL OR HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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