

APR 23 1940  
Registration District No. 496

Primary Registration District No. 3025

Registrar's No. 70

1. PLACE OF DEATH:  
(a) County Linn  
(b) City or town Brookfield  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location) 2  
(d) Length of stay: In hospital or institution 2.6 years (Specify whether years, months or days) 1/28

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Linn  
(c) City or town Brookfield  
(If outside city or town limits, write "RURAL")  
(d) Street No. 123 E. Robard. (If rural, give location)  
(e) If foreign born, how long in U. S. A.? 11 years.

3. (a) PRINT FULL NAME Margaret Jane Gullick  
8. (b) If veteran, name war: \_\_\_\_\_ 8. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month mar day 17  
year 1940 hour 11 minute 35 P.M.

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife William G. Gullick 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Oct 29 1861  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 1926 to  
mar 11 1940  
that I last saw her alive on mar 17 1940  
and that death occurred on the date and hour stated above.  
Immediate cause of death Cerebral hemorrhage Duration \_\_\_\_\_

8. AGE: Years 78 Months 4 Days 17 hr. \_\_\_\_\_ min. \_\_\_\_\_  
9. Birthplace Coumback Wales  
(City, town, or county) (State or foreign country)

Due to arteriosclerosis  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) g.m.

10. Usual occupation At Home  
11. Industry or business \_\_\_\_\_  
MOTHER FATHER { 12. Name David Morgan  
13. Birthplace Wales  
(City, town, or county) (State or foreign country)  
14. Maiden name \_\_\_\_\_  
15. Birthplace Wales  
(City, town, or county) (State or foreign country)

Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically

16. (a) Informant's town/signature \_\_\_\_\_  
(b) Address Spanish Gullick  
17. (a) Brookfield (b) Date thereof (Month) (Day) (Year) \_\_\_\_\_  
(Burial, cremation, or removal) Rose Hill Cem. Brookfield  
(c) Place: burial or cremation \_\_\_\_\_  
18. (a) Signature of funeral director Hill Chapel  
(b) Address Brookfield 445  
19. (a) 3/18/40 (b) W. B. Simpson  
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? (City or town) (County) (State) \_\_\_\_\_  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_  
While at work? (Specify type of place) (e) Means of injury \_\_\_\_\_  
23. Signature W. B. Simpson (M. D. or other) Do.  
Address Brookfield Mo Date signed 3/18/40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

REV. 5-17-39 I 119511

RECEIVED

District Health Officer No. 11,

District File Number

440-472

Date Filed APR 9

1940

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.....

J. H. Blacklock

Registered Apprentice No.....

working under my personal supervision.

Signed.....

J. H. Blacklock

Licensed Embalmer No. 2246

P. O. Address Brookfield 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 this body is not embalmed, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 115-72

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 496

Primary Registration District No. 3025

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Franklin  
(b) City or town Frankfield  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether  
In this community \_\_\_\_\_ years, months or days)

3. (a) PRINT FULL NAME

Margaret Jane Sullivan

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
78 4 17 hr. min.

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name \_\_\_\_\_

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace (City, town, or county) (State or foreign country) Wales

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof (Month) (Day) (Year)

(Burial, cremation, or removal)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) May 1 1940 (b) Montgomery  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_  
(If outside city or town limits write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Mar day 17  
year 1940 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (c) Means of injury \_\_\_\_\_

23. Signature W.B. Simpson (M. D. or other) \_\_\_\_\_  
Address Brownfield Date signed \_\_\_\_\_

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTAL

11572 (1940)