

**FILED JUL 15 1940**

Registration District No. 7

Primary Registration District No. 3001

Registrar's No. 159

**1. PLACE OF DEATH:**

(a) County Adair  
 (b) City or town Kirkville  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
1006 N. Main  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution X  
(Specify whether)  
 In this community Life Time  
years, months or days

8. (a) PRINT FULL NAME Marion Earnest Gillispie

8. (b) If veteran, X name war \_\_\_\_\_  
 8. (c) Social Security No. 489-14-7630

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

6. (b) Name of husband or wife Mae Gillispie 6. (c) Age of husband or wife if alive 60 years

7. Birth date of deceased. 3 1884  
(Month) (Day) (Year)

8. AGE: Years 56 Months 2 Days 26 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Carpenter & Painter

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

12. Name David Gillispie

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

14. Maiden name Margaret Ninick

16. Birthplace Putman County Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Mae Gillispie

(b) Address Kirkville, Mo

17. (a) Burial (b) Date thereof 6-20-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Fugate Cemetery

18. (e) Signature of funeral director B. B. Riley

(b) Address Kirkville, Mo.

19. (a) June 19/40 (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Adair  
 (c) City or town Kirkville,  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 1006 N. Main St.,  
(If rural, give location)  
 (e) If foreign born, how long in U. S. A? X \_\_\_\_\_ years.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month June day 18  
 year 1940 hour 11:30 minute 2 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 \_\_\_\_\_

suicide by hanging himself

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions 165  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy No

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) suicide

(b) Date of occurrence June 18, 1940

(c) Where did injury occur? Kirkville Adair Mo  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
Home: 1006 North Main St

3 While at work? yes

23. Signature P. A. Oliver Adair  
(Physician) (Address) (City)

Address Kirkville Date signed 6/19/40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Officer No. 10

District File Number 6-40-1315

Date Filed July 3, 1940

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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.....

Dee Riley

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Dee Riley

Licensed Embalmer No. 3908

P. O. Address Kirkville, 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. **21037**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. **1**

Primary Registration District No. **100**

Registrar's No. **153**

1. PLACE OF DEATH:

(a) County **Adair**  
(b) City or town **Festerville**  
(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..... (Specify whether  
years, months or days)

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.

3. (a) PRINT FULL NAME

**Marion Ernest Gillispie**

19. MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **18**  
year..... hour..... minute..... M.

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

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

4. Sex **M**  
5. Color or race **W**  
6. (a) Single, widowed, married, divorced **M**  
6. (b) Name of husband or wife.....  
6. (c) Age of husband, or wife, if alive..... year  
7. Birth date of deceased..... (Month) (Day) (Year)

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.....

8. AGE: Years **56** Months **2** Days **26** If less than one day..... hr..... min.

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

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

10. Usual occupation.....

Major findings:  
Of operations.....  
Of autopsy.....

11. Industry or business.....

MOTHER FATHER { 12. Name.....  
13. Birthplace..... (City, town, or county)..... (State or foreign country)  
14. Maiden name.....  
15. Birthplace..... (City, town, or county)..... (State or foreign country)

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?

16. (a) Informant.....  
(b) Address.....  
17. (a)..... (b) Date thereof..... (Month) (Day) (Year)  
(Burial, cremation, or removal)  
(c) Place: burial or cremation.....

While at work?..... (Specify type of place)  
(e) Means of injury.....

18. (a) Signature of funeral director.....  
(b) Address.....  
19. (a) **July 31, 1940** (Date received local registrar) **Spencer L. Ingleman** (Registrar's signature)

23. Signature **P. H. Oliver acting** (M. D.)  
Address **Festerville** Date signed.....

SUPPLEMENTARY

Duration  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

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

