DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 19 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 28620

Registration District No. 347 — Primary Registration District No. 3018 — Registrar's No.

1. PLACE OF DEATH:

(a) County Henry

(b) City or town Clinton (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Clinton General (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 8 hours (Specify whether years, months or days) In this community 42

2. USUAL RESIDENCE OF DECEASED:

(a) State O Missouri (b) County Henry

(c) City or town Clinton (If outside city or town limits, write "RURAL")

(d) Street No. 117 West Tebo (If rural, give location)

(e) If foreign born, how long in U. S. A.? ..... years.

3. (a) PRINT FULL NAME Donald Lee Gillespie

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 .....

6. (b) Name of husband or wife .....

6. (c) Age of husband or wife if alive ..... years

7. Birth date of deceased September (Month) 1 (Day) 1940 (Year)

8. AGE: Years | Months | Days | If less than one day 8 hr. ..... min.

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

10. Usual occupation .....

11. Industry or business .....

MOTHER / FATHER

12. Name Peter H. Gillespie

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

14. Maiden name Ruth Martin

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

16. (a) Informant's own signature Peter H. Gillespie

(b) Address Clinton

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 1 1940 (Month) (Day) (Year)

(c) Place: burial or cremation Leeper Chapel

18. (a) Signature of funeral director Spore & Son

(b) Address Clinton Mo.

19. (a) Sept 7 1940 (Date received local registrar) (b) J. R. Hampton (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 1

year 1940 hour ..... minute 3 P. M.

21. I hereby certify that I attended the deceased from Sept 1, 1940, to Sept 1, 1940; that I last saw h- alive on Sept 1, 1940; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Premature birth (6 mo)	8 Hr.
Due to:	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	

PHYSICIAN

Underline the cause to which death should be charged statistically.

Major findings: Of operations .....

Of autopsy .....

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? 313 (Specify type of place)

While at work? ..... (e) Means of injury .....

23. Signature H. Swalkus (M. D. or other) MD

Address Clinton Mo Date signed 9-1-40

(Licensed Embalmer's Statement on Reverse Side)

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

I X19511

RECEIVED
District Health Officer No. 7,
District File Number 9-40-1360
Date Filed 8-16-40

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.....

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

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.