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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 41849

Registration District No. 85 — Primary Registration District No. 1001 — Registrar's No. 1292

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

1. PLACE OF DEATH:
(a) County: BUCHANAN 3
(b) City or town: ST. JOSEPH
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: STATE HOSPITAL No. 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 5 years 3 Mo (Specify whether years, months or days)
In this community: 5 yrs 3 mths; 21 days

2. USUAL RESIDENCE OF DEACESED:
(a) State: Missouri (b) County: Nodaway
(c) City or town: Clearmont
(If outside city or town limits, write "RURAL")
Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME: SARAH GILLESPIE
3. (b) If veteran, name war: —
3. (c) Social Security No. NONE
4. Sex: fem.
5. Color or race: wht
6. (a) Single, widowed, married, divorced: single
6. (b) Name of husband or wife: —
6. (c) Age of husband or wife if alive: years
7. Birth date of deceased: August (Month) 1 (Day) 1870 (Year)

8. AGE: Years 70 | Months 4 | Days 9 | If less than one day: hr. min.

9. Birthplace: ? (City, town, or county) Illinois (State or foreign country)
10. Usual occupation: none
11. Industry or business: —
FATHER
12. Name: W. C. Gillespie
13. Birthplace: ? (City, town, or county) Illinois (State or foreign country)
MOTHER
14. Maiden name: Martha Griffith
15. Birthplace: ? (City, town, or county) Illinois (State or foreign country)
16. (a) Informant: Ray Gillespie
(b) Address: Clearmont, Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/12/40 (Month) (Day) (Year)
(c) Place: burial or cremation: Bradyville Ford
18. (a) Signature of funeral director: O B Fulton
(b) Address: Bradyville, Iowa
19. (a) 12/10/40 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 10 year 1940 hour 1:00 minute P. M.
21. I hereby certify that I attended the deceased from July 1, 1940, to December 9, 1940; that I last saw her alive on December 9th, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death: Bronchopulmonia — Duration: 2 weeks
Due to: TB pulm.
Due to: —
Other conditions (Include pregnancy within 3 months of death): Senile psychosis
Major findings: Of operations: —
Of autopsy: —

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): None
(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? (Specify type of place)
While at work? (e) Means of injury: —
23. Signature: J. R. Bennett (M. D. or other)
Address: State Hospital No 2 ST JOSEPH Date signed 12-10-40

(Licensed Embalmer's Statement on Reverse Side)

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. 3251 working under my personal supervision.

Signed O. B. Hollon

Licensed Embalmer No. 3251

P. O. Address Bruddyville Ia

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.