

No. 2
4-13-40
5-17-39
PI X29159

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 43472

JAN 25 1941
Registration District No. 668

Primary Registration District No. 3032

Registrar's No. 407

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

1. PLACE OF DEATH:
 (a) County Pettis
 (b) City or town Sedalia
 (c) Name of hospital or institution 705 East 15th St.
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 26 years
 (Specify whether years, months or days)

3. (a) PRINT FULL NAME Maud May Gilmore
 3. (b) If veteran, name war none
 3. (c) Social Security No. none

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced married
 6. (b) Name of husband or wife Charles P. Gilmore 6. (c) Age of husband or wife if alive December 26, 1882 years
 7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 58 Months 0 Days 3 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business

MOTHER FATHER
 12. Name A. R. Baker
 13. Birthplace Pennsylvania (City, town, or county) (State or foreign country)
 14. Maiden name Clara Baker
 15. Birthplace Pennsylvania (City, town, or county) (State or foreign country)

16. (a) Informant Charles P. Gilmore, (Husband)
 (b) Address 705 E. 15th, Sedalia, Mo.
 17. (a) Burial (b) Date thereof Dec. 31, 1940
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place of burial or cremation Salen Cemetery, Pettis County, Mo.
 18. (a) Signature of funeral director None
 (b) Address Sedalia, Mo.

19. (a) 12/30/40 (b) Mrs. Harry Sneed
 (Date received local registrar) (Registrar's Signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Pettis
 (c) City or town Sedalia
 (If outside city or town limits, write "RURAL")
 (d) Street No. 705 East 15th
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 29th year 194 hour 8.40 minute a M.
 21. I hereby certify that I attended the deceased from Dec 10th 1940 to Dec 29th 1940
 that I last saw her alive on Dec 29th 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death Generalized Peritonitis
 Due to Ruptured Gall Bladder
 Duration 5 days
 Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations None - Refused
 Of autopsy Refused
 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) No
 (b) Date of occurrence No
 (c) Where did injury occur? No
 (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 John B. Carls (M. D. or other)
 Address 2148 Ohio Sedalia Mo Date signed 12 30 40

127

Dr. Carlisle

SEP 3 1952

RECEIVED
District Health Officer No. 8
District File Number
Date Filed 1-14-11

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 Duane Gering
Licensed Embalmer No. 3847
P. O. Address Adalia, 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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 43472
Registrar's No. 407

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 668

Primary Registration District No. 3052

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

1. PLACE OF DEATH:

(a) County Pettis

(b) City or town Sedalia
(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.....

3. (a) PRINT FULL NAME Mandi May Gilmore

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 m

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 58 Months 0 Days 3 If less than one day..... 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.....

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

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)..... (b)..... (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.

20. DATE OF DEATH: Month Dec day 29 year 1940 hour..... minute..... M.

21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....;

that I last saw h..... alive on....., 19.....;

and that death occurred on the date and hour stated above.

Immediate cause of death: Generalized Peritonitis

Duration.....

Due to Ruptured gall bladder

Due to.....

Other conditions none Refused (Include pregnancy within 3 months of death)

Major findings: Of operations.....

Of autopsy Refused

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) (e) Means of injury.....

23. Signature Geo D Carlisle (M. D. or other)

Address Sedalia Mo Date signed.....

SUPPLEMENTARY

This patient had suffered from several attacks. Plates
had been made showing an enlarged gall bladder but
not any stones. There was no trauma - Probably an
Empyema of Gall bladder with subsequent rupture

J. B. Carlisle M.D.

2-19-46

5-43472