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FILED JUN 20 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

D of Gasperich 18350
State File No.

Registration District No. 533

Primary Registration District No. 3027

Registrar's No. 44

1. PLACE OF DEATH:

(a) County Macon
(b) City or town Macon
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Unknown
(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 John L. Gilstrap

3. (b) If veteran name was non 3. (c) Social Security No. non

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

6. (b) Name of husband or wife Single 6. (c) Age of husband or wife if alive 26 years

7. Birth date of deceased January 26 1867
(Month) (Day) (Year)

8. AGE: Years 80 Months 3 Days 5 If less than one day hr. min.

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

10. Usual occupation Farmer

11. Industry or business

12. Name Fairy Gilstrap

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

14. Maiden name Septimonia Phipps

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

16. (a) Informant Mrs Willard Phipps
(b) Address Macon Mo

17. (a) Burial (b) Date thereof May 7-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Woodlawn Cem

18. (a) Signature of funeral director Albert Skinner

(b) Address Macon Mo

19. (a) 6/6/41 (b) Seola Hunter
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Macon
(c) City or town Unknown
(If outside city or town limits, write "RURAL")
(d) Street No. Unknown
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 5 year 1941 hour 4 minute 7 M.

21. I hereby certify that I attended the deceased from Nov 18, 1940 to May 3, 1941; that I last saw him alive on May 3, 1941; and that death occurred on the date and hour stated above.

Immediate cause of death arteriosclerosis, chronic myocarditis, chronic glomerulonephritis

Due to.....
Due to.....
Other conditions (Include pregnancy within 3 months of death) 131 b

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).....
(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?

476
While at work? (Specify type of place) (a) Means of injury.....
33. Signature Frank J. Gasperich, D.O. (M.D. or other).....
Address Macon Date signed 5/21/41

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

MOTHER FATHER

RECEIVED

District Health Officer No. 10

District File Number 6-41-1122

Date Filed JUN 13 1941

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. 4066

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, fact should be so stated above.