

No. 2
1-13-40
1-17-39
X23159

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

28310

FILED SEP 15 1941
Registration District No. 318

Primary Registration District No. 2001

State File No. _____
Registrar's No. 657

9
2
6
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH
(a) County GREENE
(b) City or town Springfield
(c) Name of hospital or institution: 640 S. Weller
(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 Josiah S. Gilliland
(b) If veteran, name war no
(c) Social Security No. None

4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Wife Jennie Gilliland
6. (c) Age of husband or wife if alive Dec 7 years
7. Birth date of deceased Feb. 7 1860
(Month) (Day) (Year)

8. AGE: Years 81 Months 6 Days 5
If less than one day _____ hr. _____ min.

9. Birthplace Columbus, Johnson Co. Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer
11. Industry or business Retired

MOTHER FATHER
12. Name Abel Gilliland
13. Birthplace No Data Tenn.
(City, town, or county) (State or foreign country)
14. Maiden name Catherine Stewart
15. Birthplace No Data Tenn.
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. A. F. Bartling (Daughter)
(b) Address Springfield Missouri

17. (a) Burial (b) Date thereof 8/14/41
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Holden Cem.

18. (a) Signature of funeral director Alma Lohmeyer Funeral Home
(b) Address Springfield Missouri

19. (a) 8-14-41 (b) W. E. Haudley MD
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: 051
(a) State Missouri (b) County Johnson
(c) City or town Holden 0
(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.? 1 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 12
year 1941 hour 2 minute 30 P. M.

21. I hereby certify that I attended the deceased from 8-11 1941 to 8-12 1941;
that I last saw him alive on 8-11 1941;
and that death occurred on the date and hour stated above.

Immediate cause of death Acute pericarditis.
Duration 7 days

Due to acute chole-
cytitis
Due to chronic chole-
cytitis + lithiasis
Other conditions diverticulitis
Duodenum

Major findings: NONE 126
Of operations _____
Of autopsy SEE ABOVE.

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 [Signature] (M. D. or other) _____
Address Springfield Date signed 8/13/41

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 Wayne Linkle

Licensed Embalmer No. 3444

P. O. Address Springfield

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.

X