S. No. 2
9-4-41
5-17-39
X29484

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 21 1943

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 35926

Registration District No. 333 Primary Registration District No. 3074 Registrar's No.

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

1. PLACE OF DEATH:

(a) County Scott

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

(c) Name of hospital or institution: Sikeston Hospital, O (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 days (Specify whether In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED: 72

(a) State Missouri (b) County Newmadrid

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

(d) Street No. (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country /

3. (a) PRINT FULL NAME Nora May Gilooly,

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Married

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

6. (c) Age of husband or wife if alive 61 years

7. Birth date of deceased Feb. (Month) 14 (Day), 1885 (Year)

8. AGE: Years 58 Months 7 Days 5 If less than one day hr. min.

9. Birthplace Powatan, (City, town, or county) Ark. (State or foreign country) /

10. Usual occupation Housewife.

11. Industry or business

FATHER
12. Name Walker
13. Birthplace (City, town, or county) Ind. (State or foreign country) /

MOTHER
14. Maiden name unknown
15. Birthplace (City, town, or county) " (State or foreign country) 9

16. (a) Informant H. Hamilton Gilooly

(b) Address Parma, Mo. R. 1.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 20, 43 (Month) (Day) (Year)

(c) Place: burial or cremation Eaton, Ark. Labon Cem

18. (a) Signature of funeral director Watkins Funra l Ser.

(b) Address Dexter, Mo.

19. (a) 9-23-43 (Date received local registrar) (b) Louie Largent (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 19 day Sept year 1943 hour 5 minute 40A M.

21. I hereby certify that I attended the deceased from March, 1941, to Sept 19, 1943 that I last saw her alive on 9-19, 1943 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cerebral Hemorrhage	3 days
Due to	
Due to Arterio Sclerosis Hypertension	
Other conditions (Include pregnancy within 3 months of death)	
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? (Specify type of place)

While at work? (e) Means of injury O

23. Signature [illegible] (M. D. or other) MD

Address Mar[illegible] Mo Date signed 9/21/43

1318 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No. 2,
District File Number 1043-1290
Date Filed 10-15-43

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 Chester C. Roof

Licensed Embalmer No. 3044

P. O. Address Dexter, Mo

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

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