

S. No. 2
OM-5-43
v. 5-17-39
P I X36671

FILED DEC 28 1945

Registration District No. _____ Primary Registration District No. 5466

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

39
0
0

1. PLACE OF DEATH:

(a) County GREENE

(b) City or town Rural - S. Campbell Twp
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Medical Center for Fed. Pris., Springfield, Mo
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 months 14 days
In this community 0 2 months 14 days (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County Wyandotte 999

(c) City or town Kansas City 14
(If outside city or town limits, write "RURAL")

(d) Street No. 937 Riverview
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME GILL, Richard Laverne #5303-H

3. (b) If veteran, name war UNK.

3. (c) Social Security No. UNK.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 24th
year 1945 hour 4:25 minute A. M.

21. I hereby certify that I attended the deceased from September 10th, 19 45, to November 24th, 19 45
that I last saw him alive on November 24th, 19 45
and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife (former) Viola Leatherwood Gill

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

7. Birth date of deceased April 15, 1917
(Month) (Day) (Year)

Immediate cause of death Arteriolar nephrosclerosis **Duration 14 yrs.**

Due to _____

Due to _____

Other conditions (include pregnancy within 3 months of death) _____

8. AGE:	Years	Months	Days	If less than one day
<input checked="" type="checkbox"/>	<u>28</u>	<u>7</u>	<u>9</u>	hr. min.

Major findings:
Of operations _____

Of autopsy _____

13/10

PHYSICIAN
Underline the cause to which death should be charged statistically.

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

10. Usual occupation Laborer

11. Industry or business Construction

12. Name Claude C. Gill

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

14. Maiden name Mae (UNK.)

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

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)

Means of injury 0

23. Signature Ed Morehead (M. D. UNK.)
Address Medical Center for Fed. Pris., Springfield, Missouri Date signed 11-24-45

16. (a) Informant File

(b) Address Medical Center for Fed. Pris.

17. (a) Removal (Burial, cremation, or removal)

(b) Date thereof Nov. 24, 1945 (Month) (Day) (Year)

(c) Place: burial or cremation Kansas City, Kansas

18. (a) Signature of funeral director Ered C. Prieme

(b) Address Springfield, Mo

19. (a) 11-24-45 (Date received local registrar)

(b) S. W. Handley (Registrar's signature)

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 Fred C. Thieme

Licensed Embalmer No. 2899

P. O. Address Springfield, 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.

x