

**FILED** DEC 13 1945

Registration District No. **187**

Primary Registration District No. **3040**

Registrar's No. **139**

**1. PLACE OF DEATH:**

(a) County Livingston  
 (b) City or town Chillicothe  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
439 cherry  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
 In this community about 60 years (Specify whether years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State MO (b) County Livingston  
 (c) City or town Chillicothe MO 59  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 439 cherry  
 (If rural, give location)  
 (e) Citizen of foreign country? no (Yes or No)  
 If yes, name country \_\_\_\_\_

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Nov day 6  
 year 1945 hour 9 minute 30 A. M.

21. I hereby certify that I attended the deceased from  
Sept 26 1944 to Nov 6 1945  
 that I last saw her alive on Nov 5 1945  
 and that death occurred on the date and hour stated above.

Immediate cause of death: Chronic Myocarditis Duration unknown

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)  
 (e) Means of injury \_\_\_\_\_

23. Signature: Frances A. Neil (M. D. or other)  
 Address: Chillicothe MO Date signed: 11-8-45

3. (a) PRINT FULL NAME Catherine Seidel Gillaspie

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race white 6. (a) Single, widowed, married, divorced 9

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased June 16 1846  
 (Month) (Day) (Year)

8. AGE: Years 99 Months 4 Days 20 If less than one day hr \_\_\_\_\_ min \_\_\_\_\_

9. Birthplace Cochran Co, Ohio  
 (City, town, or county)

10. Usual occupation House wife

11. Industry or business \_\_\_\_\_

12. Name J. Seidel

13. Birthplace Ohio (State or foreign country)

14. Maiden name Dont know

15. Birthplace Dont know (State or foreign country)

16. (a) Informant Dora Gillaspie

(b) Address \_\_\_\_\_

17. (a) Burial (b) Date thereof 11-8-45  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Edgewood

18. (a) Signature of funeral director Edgewood

(b) Address Chillicothe MO

19. (a) Nov 8, 1945 (b) Frances A. Neil  
 (Date received local registrar) (Registrar's signature)

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

MOTHER FATHER

RECEIVED  
District Health Officer No. 11  
District File Number  
Date Filed

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

*was embalmed*

....., Registered Apprentice No. ....

working under my personal supervision.

Signed *E. Buckitt*

Licensed Embalmer No. *3227*

P. O. Address *Chillum*

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.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 100  
Registrar's No. 139

Registration District No. 167 Primary Registration District No. 3040

1. PLACE OF DEATH:  
(a) County Livingston  
(b) City or town Phillipmothe  
(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 \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME Catherine S. Lellaspie  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced widowed  
6. (b) Name of husband or wife Thomas L. Lellaspie 6. (c) Age of husband or wife if alive \_\_\_\_\_  
7. Birth date of deceased June 16 1903  
(Month) (Day) (Year)

8. AGE: Years 99 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country) Ohio

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 \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_  
(b) Address \_\_\_\_\_  
19. (a) \_\_\_\_\_ (b) Frances A. Neill  
(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) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month \_\_\_\_\_ Day \_\_\_\_\_  
year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_  
to \_\_\_\_\_, 19\_\_\_\_  
and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

PHYSICIAN \_\_\_\_\_  
Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

37836