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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **5981**
Registrar's No. **49**

Registration District No. **146** Primary Registration District No. **3026**

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

1. PLACE OF DEATH:
(a) County **Jackson**
(b) City or town **Independence**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
635 So. Fuller Street
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **44 Years** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Jackson**
(c) City or town **Independence**
(If outside city or town limits, write "RURAL")
(d) Street No. **635 So. Fuller Street**
(If rural, give location)
(e) Citizen of foreign country? **No.** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **JAMES ARTHUR GILLEN**
3. (b) If veteran, name war _____ 3. (c) Social Security No. **None**

4. Sex **Male** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Kate Gillen** 6. (c) Age of husband or wife if alive **65** years
7. Birth date of deceased **May 24, 1868**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
77 **8** **17** hr. min.

9. Birthplace **Malad, Iowa**
(City, town, or county) (State or foreign country)

10. Usual occupation **Minister**

11. Industry or business _____

MOTHER FATHER
12. Name **J.W. Gillen**
13. Birthplace **Ireland**
(City, town, or county) (State or foreign country)
14. Maiden name **Nancy Ann Moore**
15. Birthplace **Council Bluffs, Iowa**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Kate Gillen**
(b) Address **Independence, Missouri**
17. (a) **Burial** (b) Date thereof **2/13/46**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Mound Grove Cemetery**

18. (a) Signature of funeral director **Coland R. Speake**
(b) Address **Independence, Missouri**
19. (a) **2-13-46** (b) **James W. Ross**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **February** day **11**, year **1946** hour **8** minute **10 A.** M.
21. I hereby certify that I attended the deceased from **Sept. 3, 1929**, 19____, to **Feb. 9, 1946**, 19____; that I last saw him alive on **Feb. 8, 1946**, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death **Myocardial Infarction**
Coronary Sclerosis
Duration **3 days**
Years

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? _____
(Specify type of place) _____
While at work? (e) Means of injury _____
23. Signature **Chas. F. Grasse** (M. D. or other) **M.D.**
Address **Independence, Mo.** Date signed **2/13/46**

JUN 21 1948

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..... 7604

P. O. Address..... Indip. 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.