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FILED SEP 2 1947

Registration District No. 184

Primary Registration District No. 3032

Registrar's No. 91

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

1. PLACE OF DEATH:

(a) County Johnson
(b) City or town Warrensburg
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: none
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution none (Specify whether)
In this community 46yrs. years, months or days

3. (a) PRINT FULL NAME Amanda Frances Gillum

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

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced widow
6. (b) Name of husband or wife Robert F. Gillum 6. (c) Age of husband or wife if alive deceased
7. Birth date of deceased April 1, 1871
(Month) (Day) (Year)

8. AGE: Years 76 Months 4 Days 15 If less than one day
hr. min.

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

10. Usual occupation house wife

11. Industry or business _____

MOTHER FATHER
12. Name James F. Lawson
13. Birthplace Champaign, ILL.
(City, town, or county) (State or foreign country)
14. Maiden name Susan Ann Hurt
15. Birthplace Paris, KY.
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Addie Flannery

(b) Address Warrensburg, MO.

17. (a) burial (Burial, cremation, or removal) (b) Date thereof 8/18/1947
(Month) (Day) (Year)

(c) Place: burial or cremation Warrensburg, MO.

18. (a) Signature of funeral director Sweeney Phillips

(b) Address Warrensburg, MO.

19. (a) Aug 19 1947 (Date received local registrar) (b) Savannah Antiephila (Registrar's signature) 1/17

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Johnson 5/
(c) City or town Warrensburg 2
(If outside city or town limits, write "RURAL")
(d) Street No. 309, South Maguire 2
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No) 0
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 16,
year 1947. hour 9 minute 20 P. M.

21. I hereby certify that I attended the deceased from July 10
1944 to Aug 16, 1947
that I last saw her alive on Aug 14, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Hypostatic pneumonia
Duration 3 days

Due to pleuritis - secondary

Due to arteriosclerosis 5 years

Other conditions united fracture left femur 6 mos
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings:
Of operations _____
Of autopsy 186 18
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?

23. Signature [Signature] (M. D. or other) 0
Address Warrensburg, Mo. Date signed 8/18/47

ADDITIONAL SUPPLEMENTARY INFORMATION REQUIRED 5/

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.....

P. Q. Phillips

Licensed Embalmer No. *23 20*

P. O. Address *Warrensburg, 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.

Registration District No. *164*

Primary Registration District No. *3032*

Registrar's No.

1. PLACE OF DEATH:

(a) County *Johnson*
 (b) City or town *Warrensburg*
 (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

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 _____

3. (a) PRINT FULL NAME *Amanda J. Gillum*

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

4. Sex *F* 5. Color *w* 6. (a) Single, widowed, married, divorced *wid*

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased *April 24*
 (Month) (Day) (Year)

8. AGE: Years *76* Months _____ Days _____ If less than one day _____ hr. _____ min.

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

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 _____ (Month) (Day) (Year)
 (Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *Jan* Day *14* Year *1947*
 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ and that death occurred on the date and hour stated above. Immediate cause of death _____

Duration _____

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) *Accident*
 (b) Date of occurrence *Jan. 14, 1947*
 (c) Where did injury occur *Warrensburg Johnson Co., Mo*
 (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
Home *slipped on rug*

got up to walk across floor
 (Specify type of place)
 While at work? *fractured left hip*
 (e) Means of injury

23. Signature _____ (M. D. or other)

Address _____ Date signed _____

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

SUPPLEMENTARY

S-28162