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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 8 1948

Registration District No. 42

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1000

State File No. 4005

Registrar's No. 264

1. PLACE OF DEATH:
(a) County: Buchanan
(b) City or town: St. Joseph, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 416½ North 6th Street
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
In this community: 20 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Buchanan
(c) City or town: St. Joseph
(If outside city or town limits, write "RURAL")
(d) Street No.: 416 ½ N. 6th
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: Amma E. Gillenwater

3. (b) If veteran, name war: no

3. (c) Social Security No.: none

4. Sex: Female

5. Color or race: white

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

6. (b) Name of husband or wife: John Gillenwater

6. (c) Age of husband or wife if alive: 59 years

7. Birth date of deceased: Sept 13, 1897 (Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
50	4	18	hr. min.

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

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: Michael Hale
13. Birthplace: ---- (City, town, or county) Indiana (State or foreign country)

MOTHER
14. Maiden name: Amanda Hale
15. Birthplace: DeKalb (City, town, or county) Mo. (State or foreign country)

16. (a) Informant: John Gillenwater
(b) Address: St. Joseph, Mo.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof: 2/1/48 (Month) (Day) (Year)
(c) Place: burial or cremation: Troy, Kansas

18. (a) Signature of funeral director: E. Kasr
(b) Address: Troy, Kansas.

19. (a) 3-3-48 (Date received local registrar) (b) E. C. Jenkins (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 1st year 1948 hour 4:50 minute A M.

21. I hereby certify that I attended the deceased from March 1946 to January 31 1948 that I last saw h. alive on January 31 1948 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Heart failure	
Due to: Pneumonia	
Due to: Palsy caused by cerebral hemorrhage	
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: E. Hamlin (M. D. or other) M.D.
Address: Physicians Surgeons Building St. Joseph Mo Date signed 2/1/48

(Licensed Embalmer's Statement on Reverse Side)

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 E. L. Kane

Licensed Embalmer No. 3537

P. O. Address Troy Kans

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.