

FILED MAY 27 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

17869

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 310 PRIMARY REG. DIST. NO. 3058 Registrar's No. 82

0923

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

1. PLACE OF DEATH a. COUNTY <u>St. Charles</u>		2. USUAL RESIDENCE (Where deceased lived. *If institution: residence before death.) a. STATE <u>Missouri</u> b. COUNTY <u>St. Charles</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Charles</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Charles</u>	
c. LENGTH OF STAY (in this place) <u>10 yrs</u>		d. STREET ADDRESS (If rural, give location) <u>340 N. Main (Baldwin Hotel)</u>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>340 N. Main (Baldwin Hotel)</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Samuel</u>	b. (Middle) <u>Robert</u>	c. (Last) <u>Gilliland</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>May 19 1950</u>
---	---------------------------	----------------------------	---

5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>March 21, 1884</u>	9. AGE (In years last birthday) <u>66</u>	IF UNDER 1 YEAR Months	IF UNDER 4 HRS. Hours	Min.
--------------------	-------------------------------	---	--	---	------------------------	-----------------------	------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Porter</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Travel &amp; Hotel Agency</u>	11. BIRTHPLACE (State or foreign country) <u>New Florence, Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
---	--	---	--

13a. FATHER'S NAME <u>Thomas Gilliland</u>	13b. MOTHER'S MAIDEN NAME <u>Rebecca Knight</u>	14. NAME OF DECEASED'S WIFE <u>Martha (Mahanes) Gilliland</u>
--	---	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs Martha Gilliland</u>	ADDRESS <u>1943a Arlington St. Louis 18</u>
--	-------------------------------------	---	---

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH  <u>4201</u>
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>None</u>		

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
------------------------------	--	--

21a. ACCIDENT SUICIDE HOMICIDE (Specify) * * * * *	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____
--	--	---

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) * * * * *	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____
---	--	----------------------------------

22. I hereby certify that I ~~am the physician who attended the deceased~~ held Inquest to May 20, 1950, that I ~~was~~ was with the deceased ~~at the time of death~~, and that death occurred at 6:30 A m., from the causes and on the date stated above.

23a. SIGNATURE <u>Marie Marchand</u> (Degree or title)	23b. ADDRESS <u>3 Westville Mo</u>	23c. DATE SIGNED <u>5-20-50</u>
--	------------------------------------	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>May 23, 1950</u>	24c. NAME OF CEMETERY OR CREMATORY <u>New Florence Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>New Florence, Mo.</u>
---	-------------------------------	---	--

DATE REC'D BY LOCAL REG. <u>5/26/50</u>	REGISTRAR'S SIGNATURE <u>Harvie Samuel</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>H. C. Dallmeyer + Sons Co</u>	ADDRESS <u>H. C. Dallmeyer &amp; Sons Co</u>
---	--	---	--

RECEIVED  
MAY 26 1950  
District Health Officer No. 9,  
District File Number

MAY 29 1950

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 4189

Student Embalmer No.                     

working under my personal supervision.

Student                       
Student Embalmer

Signed Joseph I. Randoe

Licensed Embalmer No. 4189

P. O. Address St Charles

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.