

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **41215**BIRTH NO. _____ REG. DIST. NO. **322** PRIMARY REG. DIST. NO. **3071** Registrar's No. **53**

1. PLACE OF DEATH a. COUNTY Saline		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY Saline	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Slater		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Slater	
d. FULL NAME OF HOSPITAL OR INSTITUTION none		d. STREET ADDRESS (If rural, give location) 545 N. Elm	

3. NAME OF DECEASED (Type or Print)	a. (First) Henry	b. (Middle) Walker	c. (Last) Gilliam	4. DATE OF DEATH (Month) (Day) (Year) Nov. 28-1952
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5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Feb. 27-1874	9. AGE (In years last birthday) 78	IF UNDER 1 YEAR Months 9	IF UNDER 1 YEAR Days 1	IF UNDER 24 HRS. Hours Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Garage	10b. KIND OF BUSINESS OR INDUSTRY merchandising	11. BIRTHPLACE (State or foreign country) Saline County, Mo.	12. CITIZEN OF WHAT COUNTRY? U S
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13a. FATHER'S NAME Henry Gilliam	13b. MOTHER'S MAIDEN NAME Henrietta Rhoades	14. NAME OF HUSBAND OR WIFE Lula Gilliam
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. no	17. INFORMANT'S SIGNATURE OR NAME ADDRESS H.W. Gilliam, Jr. Slater-Mo.
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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.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 30 hrs 5-4-51 11-22-52
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hemorrhage from Esophagus		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. Varices Cerebral Hemorrhage		
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.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **11/17**, 19**51**, to **11-28**, 19**52**, that I last saw the deceased alive on **11-28**, 19**52**, and that death occurred at **6:45 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) W. C. McBurney, M.D.	23b. ADDRESS Slater, Mo.	23c. DATE SIGNED 11/29/52
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24a. BURIAL, CREMATION, REMOVAL (Specify) burial	24b. DATE 11/30/52	24c. NAME OF CEMETERY OR CREMATORY City Cemetery	24d. LOCATION (City, town, or county) (State) Slater, Mo.
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DATE REC'D BY LOCAL REG. 11/29/52	REGISTRAR'S SIGNATURE Mrs. Earl C. Metz	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Hill Brothers Slater, Mo
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEC 17 1952

DEC 17 1952

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed A. C. Hill

Licensed Embalmer No. 3090

P. O. Address Staten, 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.

Mrs. Hill