

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

20018

FILED JUL 16 1956

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 93 PRIMARY REG. DIST. NO. 5341 Registrar's No. 56-41

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

1. PLACE OF DEATH a. COUNTY <b>Dade</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Mo</b>		b. COUNTY <b>Dade</b>	
b. CITY OR TOWN <b>rural South TWP</b>		c. LENGTH OF STAY (in this place) <b>3mo</b>		c. CITY OR TOWN <b>Everton Mo rt</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Home Everton rtl</b>		STREET ADDRESS (If rural, give location) <b>Everton Rtl</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> <b>9-10</b>	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)		
a. (First) <b>Mary</b>	b. (Middle) <b>Ellen</b>	c. (Last) <b>Gillaspay</b>	<b>July 4</b>		<b>1956</b>

5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed.</b>	8. DATE OF BIRTH <b>Feb 2 1868</b>	9. AGE (In years last birthday) Months Days <b>88 5 2</b>	IF UNDER 1 YEAR Hours Mins.	IF UNDER 24 HRS. Hours Mins.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>house work</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Farmer</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Iowa</b>	12. CITIZEN OF WHAT COUNTRY? <b>usa</b>
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13a. FATHER'S NAME <b>David M. Gillaspay</b>	13b. MOTHER'S MAIDEN NAME <b>Elizabeth Ann Jeffers</b>	14. NAME OF HUSBAND OR WIFE <b>Wm. M. Gillaspay</b>
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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) <b>no</b>	16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Mrs Pearl Mallory Everton Mo rtl</b>
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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
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral hemorrhage</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>complete paralysis for the legs</b> DUE TO (c) <b>Bed sores</b>		
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 <b>331x</b>	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 June 1, 1956 to July 4, 1956, that I last saw the deceased alive on 7-1, 1956 and that death occurred at 8:00a h., from the causes and on the date stated above.

23a. SIGNATURE <b>W. S. Brasney M.A.</b>	(Degree or title) 23b. ADDRESS <b>Millers Mo</b>	23c. DATE SIGNED <b>7-7-56</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>July 7 1956</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Ray Springs</b>	24d. LOCATION (City, town, or county) (State) <b>Dade Co. Mo.</b>
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DATE REC'D BY LOCAL REG. <b>7-8-56</b>	REGISTRAR'S SIGNATURE <b>J. C. Canada</b>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>W.R. Allison Greenfield Mo.</b>
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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was emb  
by me, or by ..... Student Embalmer No.....  
working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed

*W. R. Allison*

Licensed Embalmer No. *44*

P. O. Address *Green*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F  
to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.