

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

61-001150

Registration District No. 139 Primary Registration District No. 2 Registrar's No. 2

TE JB AMENDED FILED VS JAN 31 1961

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

1. PLACE OF DEATH  
 a. COUNTY HOLT  
 b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN BIGELOW Length of stay in 1b 18 YEARS  
 c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Inside Limits Yes  No   
 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)  
 a. STATE MISSOURI b. COUNTY HOLT  
 c. CITY OR TOWN BIGELOW Inside Limits Yes  No   
 d. STREET ADDRESS (If outside, give location) Reside on Farm Yes  No

3. NAME OF DECEASED (Type or print) First Middle Last HAROLD LEE GILLAND  
 4. DATE OF DEATH Month Day Year JAN. 25, 1961  
 5. SEX MALE 6. COLOR OR RACE WHITE 7. Married  Never Married  Widowed  Divorced  8. DATE OF BIRTH 9-15-1905 9. AGE (last birthday) 55  
 IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.  
 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER 10b. KIND OF BUSINESS OR INDUSTRY Common LABOR 11. BIRTHPLACE (City and state or country) MOUND City, Mo. 12. CITIZEN OF WHAT COUNTRY U.S.A.  
 13a. FATHER'S NAME ALLIE GILLAND 13b. MOTHER'S MAIDEN NAME MYRTLE BURGE 14. NAME OF HUSBAND OR WIFE -  
 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. UNKNOWN 17. INFORMANT BOBBY GILLAND Address MOUND City, Mo.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
 PART I. DEATH WAS CAUSED BY:  
 IMMEDIATE CAUSE (a) Asphyxiation  
 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Inhalation of smoke  
 DUE TO (c) -  
 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Third degree burns over entire body  
 PART III. If deceased was female was there a pregnancy in last 90 days.  Yes  No  Unknown

19. WAS AUTOPSY PERFORMED? YES  NO   
 20a. ACCIDENT  SUICIDE  HOMICIDE   
 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) Three kerosene on stove - which exploded  
 20c. TIME OF INJURY Hour 7:00 a.m. Month, Day, Year 1 25 61  
 20d. INJURY OCCURRED WHILE AT WORK  NOT WHILE AT WORK  20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home 20f. CITY, TOWN, OR LOCATION Bigelow COUNTY Holt STATE Mo

21. I attended the deceased from - to - and last saw her/him alive on -  
 Death occurred at 7:15 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) J. Bruce Mike D.O. 22b. ADDRESS Mound City Mo 22c. DATE SIGNED 1/27/61  
 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 23b. DATE 1-27-1961 23c. NAME OF CEMETERY OR CREMATORY MOUNT HOPE 23d. LOCATION (City, town, or county) (State) MOUND City, Mo.

24. FUNERAL DIRECTOR ADDRESS JAMES H. Crawford Mound City, Mo. 25. DATE RECD. BY LOCAL REG. 1-27-1961 26. REGISTRAR'S SIGNATURE James H. Crawford

JUL 11 1967

**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 \_\_\_\_\_  
Signature of Student Embalmer

Signed *James H. Anderson*

Licensed Embalmer No. 4796

P. O. Address Mound City, Va

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.