

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-026032

STATE FILE NUMBER

AMENDED

Registration District No. 217 Primary Registration District No. 5786 Registrar's No. 45

ED JUL 25 1961

1. PLACE OF DEATH a. COUNTY <u>Mississippi</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Mississippi</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Ohio Township</u>		Length of stay in 1b <u>6 Hours</u>		c. CITY OR TOWN <u>Charleston</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>7 mls. East of Charleston</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>303 S. Virginia St.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Dane</u> Middle <u>(none)</u> Last <u>Gillispie</u>				4. DATE OF DEATH Month <u>July</u> Day <u>15</u> Year <u>1961</u>					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>12/11/17</u>	9. AGE (last birthday) <u>43</u>	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) <u>Attendant</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Service Station</u>		11. BIRTHPLACE (City and state or country) <u>Caruthersville, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA.</u>		
13a. FATHER'S NAME <u>Ananias Gillispie</u>			13b. MOTHER'S MAIDEN NAME <u>Jessie Brooks</u>			14. NAME OF HUSBAND OR WIFE <u>None</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>Yes 12/23/40 to 12/22/45</u>			16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mrs. Robert Kepner, Cario, Ill.</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractured Skull</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input checked="" type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>Struck on the skull multiple times with</u>					
20c. TIME OF INJURY Hour _____ a.m. _____ <u>Approx. 3:45 A.M.</u>	Month <u>7</u> Day <u>15</u> Year <u>61</u>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>an unknown instruments by an unknown person or person</u>							
20d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Service Station</u>		20f. CITY, TOWN, OR LOCATION <u>near Charleston</u>		COUNTY <u>Miss.</u>		STATE <u>Mo.</u>	
21. I attended the deceased from <u>after death as Coroner</u> and last saw her/him alive on _____ Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>Elvin McMikle, Coroner</u>				22b. ADDRESS <u>Charleston, Mo</u>			22c. DATE SIGNED <u>7/19/61</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>7/18/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>IOOF Cemetery</u>		23d. LOCATION (City, town, or county) <u>Charleston, Missouri</u>					
24. FUNERAL DIRECTOR <u>McMikle, Charleston, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>7-21-61</u>		26. REGISTRAR'S SIGNATURE <u>Dorothy Hathorn</u>				

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 DATE AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF

JUL 26 1961

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 BRUCE R. AUSTIN, Student Embalmer No. 613

working under my personal supervision.

Student Bruce R. Austin
Signature of Student Embalmer

Signed Edwin McMillan

Licensed Embalmer No. 4695

P. O. Address Charleston, W. 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.