

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-036563

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1031

FILED NOV 6 1961

1. PLACE OF DEATH a. COUNTY <b>Greene</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>N. Carolina</b> COUNTY <b>CARTAREE</b>	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <b>Springfield, Missouri</b>		Length of stay in 1b <b>271 days</b>	c. CITY OR TOWN <b>Beaufort</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Medical Center for Federal Prisoners</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>R.F.D.#1</b> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Linwood</b> Middle <b>None</b> Last <b>Gillikin</b>			4. DATE OF DEATH Month <b>10</b> Day <b>26</b> Year <b>'61</b>			
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>9/2/14</b>	9. AGE (last birthday) <b>47</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>carpenter</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	11. BIRTHPLACE (City and state or country) <b>Beaufort, North Carolina</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Cicero Thomas Gillikin</b>	13b. MOTHER'S MAIDEN NAME <b>Unknown</b>	14. NAME OF HUSBAND OR WIFE <b>Cleo Mae Gillikin (sep)</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>unknown</b>	16. SOCIAL SECURITY NO.	17. INFORMANT <b>MCFP Files</b> Address <b>Springfield, Missouri</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>Respiratory insufficiency</b>		<b>15 min.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Pulmonary emphysema</b>	<b>4 years</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) <b>Right ventricular hypertrophy</b>		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
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT WORK <input 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.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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21. I attended the deceased from <b>1-28-61</b> to <b>10-26-61</b> and last saw her/him alive on <b>10-26-61</b> Death, occurred at <b>2:45 P.M.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.
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21. SIGNATURE (Degree or Title) <b>Clarence Kooiker, MD</b> <i>Clarence Kooiker</i>	21b. ADDRESS <b>MCFP Springfield, Missouri</b>	22c. DATE SIGNED <b>10/27/61</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>10/28/61</b>	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State) <b>Morehead City, N.C.</b>
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24. FUNERAL DIRECTOR ADDRESS <b>H.H. Lohmeyer Funeral Home Springfield, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>10-30-61</b>	26. REGISTRAR'S SIGNATURE <b>Effie G. Melton</b>
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DATE AMENDED  
 ITEM NO.  
 SHOULD READ  
 BY AFFIDAVIT OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 INSTEAD OF  
 ADVISORY STATEMENTS ON THIS RECORD ARE TO BE FOLLOWS

**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 *R. L. McCann*

Licensed Embalmer No. 2727

P. O. Address *R. L. McCann*

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.