

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-040176

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

042

1000

1157

STATE FILE NUMBER

AMENDED

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

**FILED NOV 20 1961**

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Buchanan</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Joseph, Missouri</b>		Length of stay in 1b	c. CITY OR TOWN <b>St. Joseph, Missouri</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Missouri Methodist Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>310 South 11th Street</b>
3. NAME OF DECEASED (Type or print) First <b>LAURA</b> Middle _____ Last <b>GILLESPIE</b>		4. DATE OF DEATH Month <b>November</b> Day <b>11</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 7, 1878</b>
9. AGE (last birthday) <b>83</b>		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) <b>Retired Manager</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hiatt Coal Co.</b>	11. BIRTHPLACE (City and state or country) <b>LaChauxde Fonds, Switzerland</b>
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		13a. FATHER'S NAME	
13b. MOTHER'S MAIDEN NAME		14. NAME OF HUSBAND OR WIFE <b>August S. Gillespie</b>	
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 <b>Nephew</b> Address <b>Mr. Frank H. Voss-1302 North 22nd Street</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro-vascular Thrombosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>5 weeks</b>
DUE TO (b) <b>Arteriosclerosis</b>			<b>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 (e) <b>Hypertensive and Arteriosclerotic Heart Disease</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
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____			
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
21. I attended the deceased from <b>Oct. 8, 1961</b> to <b>Nov. 11, 1961</b> and last saw <sup>her</sup> <del>him</del> alive on <b>Nov. 11, 1961</b>		Death occurred at <b>9:10 PM</b> m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) <b>Allen J. Herman M.D.</b>		22b. ADDRESS <b>706 Francis St. Joseph, Mo.</b>	22c. DATE SIGNED <b>11-14-61</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Nov. 14, 1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Joseph, Missouri</b>
24. FUNERAL DIRECTOR <b>Meierhoffer-Fleeman Inc., St. Joseph, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>Nov. 17, 1961</b>	26. REGISTRAR'S SIGNATURE <b>Mrs. Clark Handell</b>

DATE AMENDED

INSTEAD OF

DOCUMENT

BY AFFIDAVIT OF **A. J. Herman Medical Certification**

ITEM NO. SHOULD READ

**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 Raymond A. Moore

Licensed Embalmer No. 5147

P. O. Address St Joseph

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.