

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-024085

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 140 Primary Registration District No. 3024 Registrar's No. 66

FILED JUL 10 1963

VS 300
Rev. 4/59

DATE AMENDED

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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) | |
| a. COUNTY <u>Howard</u> | | a. STATE <u>Missouri</u> b. COUNTY <u>Howard</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Fayette</u> | | c. CITY OR TOWN <u>Fayette</u> | |
| Length of stay in 1b <u>3 months</u> | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Shields Rest Home</u> | | d. STREET ADDRESS (If outside, give location) <u>306 S. Main St.</u> | |
| Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |

| | | | | | | | |
|--|-------------------------------|--|--|--|--|--|--|
| 3. NAME OF DECEASED | | | 4. DATE OF DEATH | | | | |
| First <u>BESSIE</u> Middle <u>MAY</u> Last <u>GILLUM</u> | | | Month <u>June</u> Day <u>28</u> Year <u>1963</u> | | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/> | 8. DATE OF BIRTH <u>3/1/82</u> | 9. AGE (last birthday) <u>81</u> | IF UNDER 1 YEAR | IF UNDER 24 HR | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u> | | 11. BIRTHPLACE (City and state or country) <u>Charlton Co. Mo.</u> | | 12. CITIZEN OF WHAT COUNTRY <u>USA</u> | |
| 13a. FATHER'S NAME <u>T. K. Ancell</u> | | | 13b. MOTHER'S MAIDEN NAME <u>Sarah Cleek</u> | | 14. NAME OF HUSBAND OR WIFE <u>William Gillum</u> | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of <u>No</u>) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address <u>Mrs Bernard Brehm Kansas City, Mo</u> | | |

| | | |
|--|--|----------------------------------|
| 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) <u>Cardiovascular disease</u> | | <u>10 yrs.</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Chronic metabolic deficiency</u> | | <u>50 yrs.</u> |
| DUE TO (c) <u>mental deterioration</u> | | <u>5 yrs.</u> |
| 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 female was there a pregnant in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> N <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 | | 20g. COUNTY STATE |

21. I attended the deceased from Mar. 1946 to June 28-63 and last saw her alive on June 27-63. Death occurred at 3:30 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Am C. Shaw M.D. (degree or title) 22b. ADDRESS Fayette Mo. 22c. DATE SIGNED 6-29-63

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE 6/30/63 23c. NAME OF CEMETERY OR CREMATORY Fayette City Cemetery 23d. LOCATION (City, town, or county) Fayette Missouri

24. FUNERAL DIRECTOR Ralph A. Carr ADDRESS Fayette, Mo 25. DATE RECD. BY LOCAL REG. 6-29-63 26. REGISTRAR'S SIGNATURE Katherine Welch

USE BLACK INK OR TYPEWRITER RIBBON

2011-10-10-1008

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 Ralph A. Carr

Licensed Embalmer No. 3340

P.O. Address Jayette, Mo.

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.

Print name 6-29-63

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