

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

40329  
Do not use this space.

1. PLACE OF DEATH  
 (a) County Montgomery Registration District No. 595  
 (b) Township Wellsville Primary Registration District No. 4353 Registered No. 22  
 (c) City Wellsville Mo (d) State No. Mo  
 (e) Length of residence in city or town where death occurred 44.5 yrs. mos. ds. (f) How long in U.S. if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Hermie Cottle Gilliland  
 (a) Residence, No.                      St.                      (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Female  
 4. COLOR OR RACE White  
 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (with the word) Widow  
 5A. IF MARRIED, WIDOWED, OR DIVORCED, HUSBAND OR (OR) WIFE OF W.R. Gilliland  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 27-1854  
 7. AGE YEAR 80 MONTHS - DAYS 11 IF LESS than 1 day, hrs. or min.  
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. at home  
 9. Industry or business in which work was done, as saw mill, bank, etc. same  
 10. Date deceased last worked at this occupation (month and year)                       
 11. Total time (years) spent in this occupation 4

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 7 1939  
 22. I HEREBY CERTIFY, That I attended deceased from Oct 29 1939 to Nov 7 1939  
 and was not alive on Nov 1 1939 Death is said to have occurred on the date stated above, at 4:30 m.  
 The principal cause of death and related causes of importance were as follows:  
Coronary occlusion Date of onset Nov 7-39  
59  
 Other contributory causes of importance: Diabetes Mellitus 1930  
 Name of operation                      Date of                       
 What test confirmed diagnosis                      Was there an autopsy? no  
 23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide?                      Date of injury                     , 19                      
 Where did injury occur?                      (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.  
 Manner of injury                       
 Nature of injury                       
 24. Was disease or injury in any way related to occupation of deceased? no  
 If so, specify                       
 (Signed) R. G. Hereford M. D.  
                     (Address)                     

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St Charles Co Mo  
 13. NAME Ora Cottle  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St Charles Co Mo  
 15. MAIDEN NAME Emmett Hickley  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St Charles Co Mo  
 17. INFORMANT (ADDRESS)                       
 18. BURIAL, CREMATION OR REMOVAL PLACE Wellsville Mo  
 19. FUNERAL DIRECTOR (NAME) (ADDRESS)                       
 20. FILED Nov 9 1939                                            
                     Local Registrar.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

R. G. HEREFORD, M. D.  
WELLSVILLE, MO.

**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, W.B. Hall

....., or by .....

Registered Apprentice No....., working under my personal supervision

Signed.....

Licensed Embalmer No. 1588

P. O. Address. Felleville 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 this body is not embalmed, above space should be left blank.**