WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.

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

PLACE OF DEATH

County Pettis

Township or Village or City Sedalia (No. St.; Ward)

Registration District No. 668 File No. 1 22558

Primary Registration District No. 3032 Registered No. 191

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Lillian B Aldred

PERSONAL AND STATISTICAL PARTICULARS	
SEX	Female
COLOR OR RACE	White
SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)	Single
DATE OF BIRTH (Month) (Day) (Year)	7 - 13 - 1915
AGE	— yrs. — mos. 9 ds.
If LESS than 1 day, ...hrs. or ...min.?	
OCCUPATION (a) Trade, profession, or particular kind of work	none
(b) General nature of industry, business, or establishment in which employed (or employer)	none
BIRTHPLACE (City or town, State or foreign country)	Sedalia Mo.
NAME OF FATHER	Unknown
BIRTHPLACE OF FATHER (City or town, State or foreign country)	
MAIDEN NAME OF MOTHER	Emma McKee Aldred
BIRTHPLACE OF MOTHER (City or town, State or foreign country)	Kansas City Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Emma Aldred

(ADDRESS) Sedalia Mo.

Filed July 22 1915 R. B. Rossy REGISTRAR

2

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH July 22, 1915 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from July 17, 1915, to July 22, 1915, that I last saw her alive on July 21, 1915, and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

inanition

157 D

158

151

(Duration) ... yrs. ... mos. 9 ds.

Contributory (SECONDARY) Malformation of liver & bile ducts

(Duration) ... yrs. ... mos. 9 ds.

(Signed) W. T. Walsh M. D.

7-22 1915 (Address) Sedalia Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ... yrs. ... mos. 4 ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted if not at place of death?

Former or usual residence 1224 W 2nd St. Sedalia Mo

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Crown Hill	7/22 1915

UNDERTAKER	ADDRESS
Cornelison	Sedalia

PLACE OF DEATH

County.....

Township.....
or
Village.....
or
City.....(NO.....St.:.....Ward)

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

Registration District No..... File No.....

Primary Registration District No..... Registered No.....

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME.....

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

.....(Month) .....(Day) 1.....(Year)

AGE

.....yrs.....mos.....ds.

If LESS than 1 day,.....hrs. or.....min.?

OCCUPATION
(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant).....

(ADDRESS).....

Filed ....., 191.....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

.....(Month) .....(Day) 191.....(Year)

I HEREBY CERTIFY, that I attended deceased from .....,191....., to.....,191.....,

that I last saw h.....alive on.....,191.....,

and that death occurred, on the date stated above, at.....m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

.....(Duration).....yrs.....mos.....ds.

Contributory.....
(SECONDARY)

.....(Duration).....yrs.....mos.....ds.

(Signed).....M. D.

....., 191..... (Address).....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
	....., 191....
UNDERTAKER	**ADDRESS**

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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