

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

Do not use this space.

17194

**1. PLACE OF DEATH**

County Saline  
Township.....  
City Marshall

Registration District No. 796  
Primary Registration District No. 3038

File No.....  
Registered No. 67  
St. .... Ward)

**2. FULL NAME**

Lillie B. Cyres

(a) Residence. No. .... St. .... Ward. ....

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U.S., if of foreign birth?

yrs.

mos.

ds.

**PERSONAL AND STATISTICAL PARTICULARS**

**3. SEX**

Female

**4. COLOR OR RACE**

White

**5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)**

Married

**5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF**

Frank Cyres

**6. DATE OF BIRTH (MONTH, DAY AND YEAR)**

May 9-1859

**7. AGE**

YEARS

MONTHS

DAYS

IF LESS than 1 day, .... hrs. or .... min.

67

11

28

**8. OCCUPATION OF DECEASED**

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

House Keeper

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

(c) Name of employer

**9. BIRTHPLACE (CITY OR TOWN)**

(STATE OR COUNTRY)

Mo

**10. NAME OF FATHER**

Thos J. Winning

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

(STATE OR COUNTRY)

Pa

**12. MAIDEN NAME OF MOTHER**

Margaret H. Cyres

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

(STATE OR COUNTRY)

Pa

**14.**

INFORMANT

(Address)

Frank Cyres  
Marshall Mo

**15.**

FILED

5/9, 1927  
H. H. Manning  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH (MONTH, DAY AND YEAR)**

May 7 1927

**17.**

I HEREBY CERTIFY, That I attended deceased from Feb

1927, to May 7, 1927.

that I last saw him alive on May 7, 1927, and that death occurred, on the date stated above, at 6-30 P. m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

135B

17006 Chronic Gastritis

133B

Secret (duration) yrs. .... mos. .... ds.

CONTRIBUTORY (SECONDARY)

by uterine suppuration (duration) yrs. 2 mos. .... ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH, .....

**19. DID AN OPERATION PRECEDE DEATH?**

no DATE OF .....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) Geo. B. H. H. H. H., M. D.

19, 1927 (Address) Marshall Mo

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

**19. PLACE OF BURIAL, CREMATION, OR REMOVAL**

**DATE OF BURIAL**

Bridge Park Cem May 9 1927

**20. UNDERTAKER**

**ADDRESS**

R. W. Campbell Marshall

746B

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.

PERMANENT RECORD

