

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

Do not use this space.

21367

1. PLACE OF DEATH

County Jackson Registration District No. 399 File No. _____
 Township Law Primary Registration District No. 1002 Registered No. 2712
 City W. C. Mo. (No. 4344 Rockhill Rd) St. _____ Ward _____

2. FULL NAME

Lillie Ethel Manning
 (a) Residence No. 4344 Rockhill St. Rd 7th rd. _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 10, 1888

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
46 | 8 | 26 | _____

8. OCCUPATION OF DECEASED

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

10. NAME OF FATHER E. Allen

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Kentucky

12. MAIDEN NAME OF MOTHER Mary Day

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Kentucky

14. INFORMANT Missie Day
 (Address) 2333 Dummer

15. FILED 7/7 27 M. M. Brown REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 6th 1927

17. I HEREBY CERTIFY, That I attended deceased from Jan 1st 1924 to July 6th 1927, (that I last saw her alive on July 6th 1927, and that death occurred, on the date stated above, at 7:20 P. M.)

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Carcinoma of Cervix
 48 713 4th (duration) 3 yrs. _____ mos. _____ da.
 CONTRIBUTORY Extension - Anemia - Exhaustion (duration) 1 yrs. _____ mos. _____ da.

18. WHERE WAS DISEASE CONTRACTED Tennessee; Mo
 IF NOT AT PLACE OF DEATH: _____

19. DID AN OPERATION PRECEDE DEATH? No DATE OF _____
 WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Usual methods
 (Signed) L. A. Martz, M. D.
7/7, 1927 (Address) 815 McGee

*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 Forest Hill DATE OF BURIAL July-8 1927

20. UNDERTAKER Mrs. C. L. Foster ADDRESS W. C. Mo.

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.

