

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

Do not use this space.

15828

15558

File No. _____
Registered No. 15 _____
St. _____ Ward _____

JUL 11 1928

1. PLACE OF DEATH
County Stoddard Registration District No. 839.
Township Clark Primary Registration District No. 6100
City _____ (No. _____) _____ St. _____ Ward _____

2. FULL NAME Lillie Alma Alexander
(a) Residence. No. _____ St. _____ Ward _____
(Usual place of abode) (If nonresident give city or town and State)
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
6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1889-2-3
7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min. 39 2 10
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House Keeping
(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 John Edwards
11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Tenn.
12. MAIDEN NAME OF MOTHER Gray Simpson
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Tenn.

14. INFORMANT Charles Alexander
(Address) Porterwood

15. FILED 5/11/28 J.P. Brouder REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 13 - 1928
17. I HEREBY CERTIFY That I attended deceased from 4/13 1928 to 4/13 1928
that I last saw h. e. alive on 4/13 1928, and that death occurred, on the date stated above, at 11 _____ p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pneumonia Eclampsia
146
148
CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED _____ IF NOT AT PLACE OF DEATH at place of death
DID AN OPERATION PRECEDE DEATH? no DATE OF _____
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Symptoms
(Signed) Edward Ford M. D.
, 19 _____ (Address) Parma 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 Harper Cemetery DATE OF BURIAL Apr 14 1928
20. UNDERTAKER T.C. Knight ADDRESS Parma

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.

APR 6 1942