

EC 29 1928

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

Do not use this space.

34221

1. PLACE OF DEATH

County Miller  
Township Richwoods  
City Iberia

Registration District No. 562  
Primary Registration District No. 5757

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

2. FULL NAME

Mary Elizabeth Lilly

(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. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

6. MARRIED, WIDOWED, OR DIVORCED (husband or wife) Samuel Lilly

7. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb. 17-1851

8. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 77 8 17

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Brunley  
(STATE OR COUNTRY)

10. NAME OF FATHER John Sum

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

12. MAIDEN NAME OF MOTHER Nanely Sours

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

14. INFORMANT Perry Humphrey  
(Address) Iberia, Mo.

15. FILED Dec 10, 28 W. A. Don Krenz  
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct-29-1928

17. I HEREBY CERTIFY, That I attended deceased from ..... 19....., to ..... 19..... that I last saw h..... alive on ..... 19....., and that death occurred, on the date stated above, at ..... a..... m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Had no Doctor  
209 B  
CONTRIBUTORY (SECONDARY) (duration) ..... yrs. .... mos. .... ds.

18. WHERE WAS DISEASE CONTRACTED  
IF NOT AT PLACE OF DEATH.....

19. DID AN OPERATION PRECEDE DEATH?..... DATE OF.....  
WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....  
(Signed)....., M. D.  
, 19 (Address)

\*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 Billings Cemetery DATE OF BURIAL Oct-30-1928

20. UNDERTAKER C. L. Casey ADDRESS Iberia, Mo.

Every item of information should be carefully examined, and each 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**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Miller  
Township Richards  
City Richards (No.       )

Registration District No. 562  
Primary Registration District No. 2937

File No.         
Registered No.         
St.        Ward       

**2. FULL NAME**

Mary Elizabeth Lilly  
(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. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) W

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day,        hrs. or        min.

**8. OCCUPATION OF DECEASED**

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

10. NAME OF FATHER       

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Do not know

12. MAIDEN NAME OF MOTHER       

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Do not know

14.

INFORMANT (Address)       

15.

FILED Jan 7 19 1919 W. A. Warkrup REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 29 1928

17. I HEREBY CERTIFY That I attended deceased from        1928 that I last saw him        alive on        1928, and that death occurred, on the date stated above, at        IN       .

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

CONTRIBUTORY (SECONDARY)        (duration)        yrs.        mos.        ds.

18. WHERE WAS DISEASE CONTRACTED        (duration)        yrs.        mos.        ds.

IF NOT AT PLACE OF DEATH       

DID AN OPERATION PRECEDE DEATH?        DATE OF       

WAS THERE AN AUTOPSY?       

WHAT TEST CONFIRMED DIAGNOSIS?       

(Signed)       , M. D.

, 19 28 (Address)       

\*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

19

20. UNDERTAKER ADDRESS       

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

7. Every item of information supplied on this certificate should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be readily understood. State statement of OCCUPATION is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR THIS SUPPLEMENTARY RECORD UN'TIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-34221