

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

Do not use this space.

7367

**1. PLACE OF DEATH**

County New Madrid  
Township "  
City " (No. ....)

Registration District No. 604  
Primary Registration District No. 5802

File No. 22  
Registered No. ....  
St. .... Ward

**2. FULL NAME**

Lillie May Caruthers

(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 Female 4. COLOR OR RACE Negro 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug - 26 - 1926

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>2</u>	<u>5</u>	<u>7</u>	

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work None  
(b) General nature of industry, business, or establishment in which employed (or employer) .....  
(c) Name of employer .....

9. BIRTHPLACE (CITY OR TOWN) Kennett, Mo.  
(STATE OR COUNTRY)

10. NAME OF FATHER Tom Caruthers

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

12. MAIDEN NAME OF MOTHER Ada Broggin

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

14. INFORMANT Tom Caruthers  
(Address) Kennett, Mo

15. FILED 2/5/29 W. Bannan  
19.29 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-3-29

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..... 11:30 p.m.

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

Pneumonia  
10-10-28 Bronchial  
(duration) ..... yrs. .... mos. .... da.

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

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH? .....

8 DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? .....

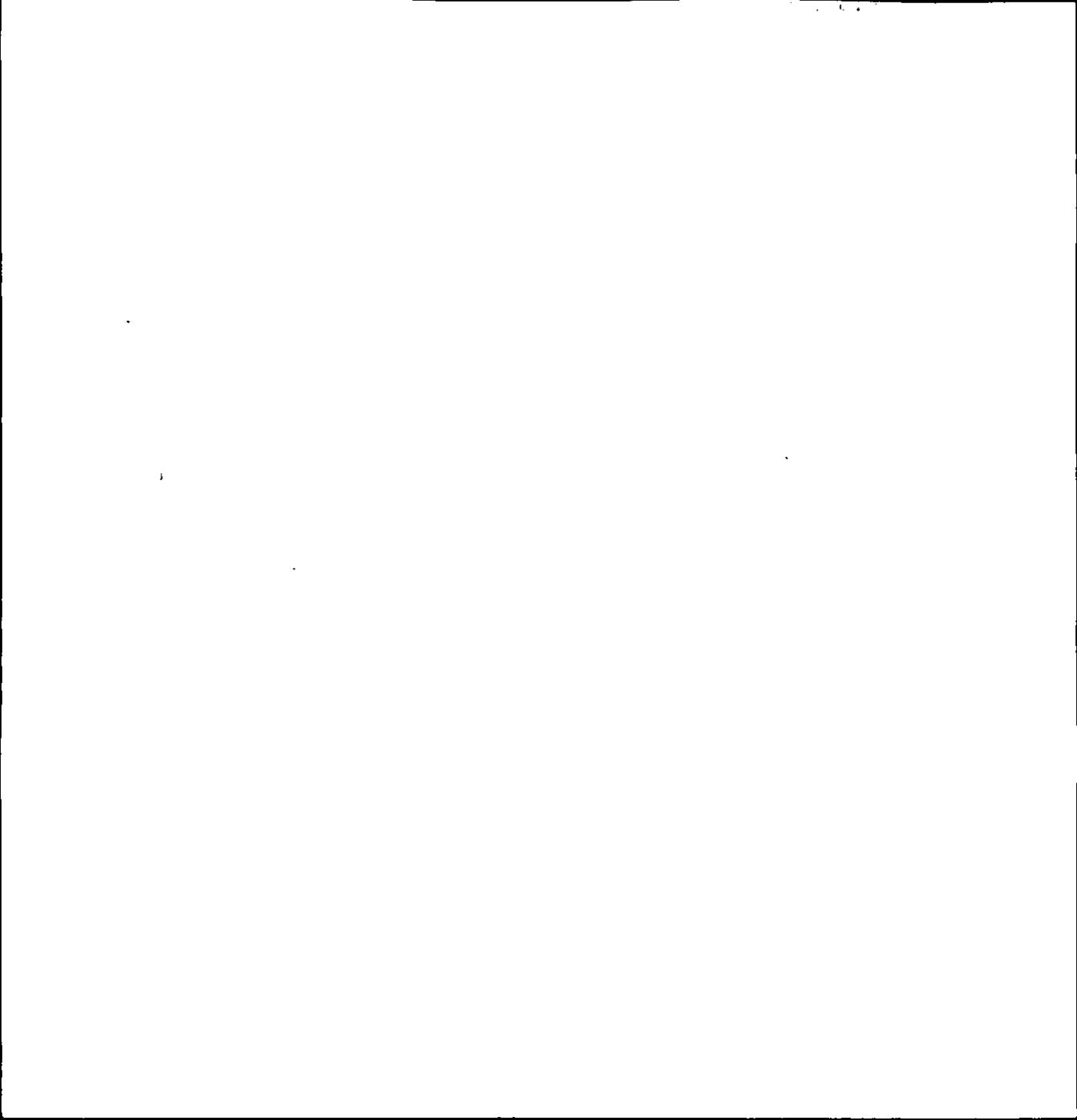
WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) W. L. Dwyer, M. D.  
, 19 (Address) New Madrid

\*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 Kennett, Mo DATE OF BURIAL 2-5-29

20. UNDERTAKER Richardson, Co ADDRESS New Madrid



**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 New Madrid Registration District No. 604 File No. ....  
 Township ..... Primary Registration District No. 1-802 Registered No. ....  
 City ..... (No. ....) St. .... Ward)

2. FULL NAME

Lillie May Couthers

(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 F 4. COLOR OR RACE Col 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) S

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)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

14. INFORMANT (Address) .....

15. FILED 2/5/29 W. W. Barnes REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2 - 3 19 29

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..... m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Bradical pneumonia  
Unknown  
 (duration) ..... yrs. .... mos. .... ds.

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

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 (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

RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW REGISTRAR.

SUPPLEMENTARY

S-7367