

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

Do not use this space.

9226

1. PLACE OF DEATH

County Stone.
Township Pine.
City..... (No.....)

Registration District No. 1033.
Primary Registration District No. 6113.

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

2. FULL NAME Lillie T. Allred.

(a) Residence. No..... St. Ward.....
(Usual place of abode)
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.
(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.

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 11, 1857.

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, ... hrs. or min.
	<u>71</u>	<u>10</u>	<u>28.</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At the home of her
(b) General nature of industry, business, or establishment in which employed (or employer) Son-in-law.
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Kentucky.

10. NAME OF FATHER William P. Barrett.

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

12. MAIDEN NAME OF MOTHER Elizabeth Wheeler

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

14. INFORMANT Mathew A. Trimble

(Address) Blue Eye, Mo.

15. FILED 2/10 1929 Chas. D. Scott
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 9th, 1929.

17. I HEREBY CERTIFY, That I attended deceased from Dec. 8th, 1928, to Feb. 9th, 1929.
that I last saw h. or alive on Feb. 7th, 1929, and that death occurred, on the date stated above, at 4 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Bronchitis associated
With Asthma.

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

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

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) E. E. Miller, M. D.

2 / 9 / 1929 (Address) Blue Eye, 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

Butler Cemetery 2/10 1929
20. UNDERTAKER Opell Butler ADDRESS Blue Eye, 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.

