

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

Do not use this space.

40024

1. PLACE OF DEATH

County Livingston Registration District No. 508
Township _____ Primary Registration District No. 3026
City Shillice (No. _____) St. _____ Ward _____

File No. _____
Registered No. 262

2. FULL NAME

Mrs Lucy Jane Lindell
(a) Residence No. 729 Millersville 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 (prior the word) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED—HUSBAND OF (OR) WIFE OF Robert M. Lindell

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct. 31, 1862

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
68 1 12

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) Browning
(STATE OR COUNTRY) Mo

10. NAME OF FATHER Caleb Cotten

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

12. MAIDEN NAME OF MOTHER Martha Neal

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

14. INFORMANT Madeline Jacobs
(Address) Shillice Mo.

15. FILED 12/15 1930 Benjamin Berney
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec. 15th 1930

17. I HEREBY CERTIFY, That I attended deceased from Dec. 13, 1930 to Dec. 13, 1930 that I last saw her alive on 13 day, 1930, and that death occurred, on the date stated above, at 1:00 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Stricture of Esophagus
116^{hr}

110 162 (duration) yrs. 1 mos. 13 ds.

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

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? X-Ray, Fluoroscope
(Signed) M. E. Calliatt, D.O., M.D.

Decs. 19 30 (Address) Chillicothe, 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 Edge Wood DATE OF BURIAL 12/15th 1930

20. UNDERTAKER Meinshagen & Marshall ADDRESS Shillice 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.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

NOV 20 1930

