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

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.

AUG 23 1932

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

Do not use this space.

1. PLACE OF DEATH

39 County Greene — Registration District No. 317 — File No. 22490

Township Republic — Primary Registration District No. 5436 — Registered No.

City ..... (No. ..... St. ..... Ward)

2. FULL NAME Ernest Lloyd

(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: Male
4. COLOR OR RACE: White
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) July 15, 1932

7. AGE — YEARS: — MONTHS: — DAYS: 1 — If LESS than 1 day, 25 hrs. or — min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: at home
(b) General nature of industry, business, or establishment in which employed (or employer): —
(c) Name of employer: —

9. BIRTHPLACE (CITY OR TOWN) Republic Mo RR #2
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER Ernest Fyan Lloyd
11. BIRTHPLACE OF FATHER (CITY OR TOWN) ..... (STATE OR COUNTRY) Greene Co Mo
12. MAIDEN NAME OF MOTHER Bramlet Frances
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ..... (STATE OR COUNTRY) Ark

14. INFORMANT Fyan Lloyd
(Address) Republic Mo RR #2

15. FILED 7/17 1932 V. W. Shaver REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 17 1932

17. I HEREBY CERTIFY, That I attended deceased from July 15, 1932, to July 17, 1932 that I last saw him alive on July 16, 1932, and that death occurred, on the date stated above, at 12 45 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Atelectasis
16 7 6 1 a
(duration) — yrs. — mos. 15 ds.

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

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? (1)
DID AN OPERATION PRECEDE DEATH? no. DATE OF —
WAS THERE AN AUTOPSY? no.
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) E. M. LeCompte, M. D.
, 19 (Address) Brookline Sta 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: Brookline Cemetery — DATE OF BURIAL: 7/17 1932

20. UNDERTAKER: R E Thurman — ADDRESS: Republic Mo