

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.

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

Do not use this space.

4096

File No. _____
Registered No. **1064**
St. _____ Ward _____

1. PLACE OF DEATH
County _____ Registration District No. _____
Township _____ Primary Registration District No. _____
City **St. Louis** (No. **City Hospital**)

2. FULL NAME **Eva Lillis**
(a) Residence, No. **4521 Page** Ward **11**
(Usual place of abode)
Length of residence in city or town where death occurred **36** yrs. **0** mos. **0** 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) **married**
5A. IF MARRIED, WIDOWED, OR DIVORCED, HUSBAND OF (OR) WIFE OF **John B. Lillis**

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **Aug. 18-1862**
7. AGE YEARS **70** MONTHS **5** DAYS **10**
If LESS than 1 day, _____ hrs. or _____ min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. **Housework**
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Lansing Michigan**

13. NAME **John Kessler**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Pa.**

15. MAIDEN NAME **Anna Vandervoll**

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **St. Louis**

17. INFORMANT (ADDRESS) **City Hospital**

18. BURIAL, CREMATION, OR REMOVAL
PLACE **Walhallu Crematory** DATE **Jan 31** 19**33**

19. UNDERTAKER **Geo. L. Plechsch Inc.**
(ADDRESS) **515 S. 9th St. St. Louis**

20. FILED _____ 19____
Wm. C. Stanley Registrar

3 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Jan. 28th 1933**
22. I HEREBY CERTIFY, that I attended deceased from **Jan. 11th 1933** to **Jan. 28th 1933**
Last saw her alive on **Jan. 28th 1933** Death is said to have occurred on the date stated above, at **7:00 A.M.**
The principal cause of death and related causes of importance were as follows:

Chronic Myocarditis
Hypostatic Pneumonia
Gangrene of Toes
Other contributory causes of importance: **950**
Name of operation **Amputation** Date of _____
What test confirmed diagnosis? **Culture** Was there an autopsy? **No**

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____ 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased?
If so, specify _____
(Signed) **Raymond W. Gable** M. D.
(Address) **City Hospital**

L. L. L.