

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

Do not use this space.

APR 22 1935

9828

1. PLACE OF DEATH

County Marion
Township Mason
City Hannibal (No. St. Elizabeth Hospital)

Registration District No. 547
Primary Registration District No. 3099

File No. 89
Registered No. 62 Ward

2. FULL NAME

Lillie Catherine Rager

(a) Residence, No. Philadelphia Mo. St. Ward.

(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 (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan 7, 1870

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
65 2 2

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife

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. Life

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mauvo Ill.

13. NAME Frances H. Brown

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Virginia

15. MAIDEN NAME Laura S. Ward

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Middletown Ohio

17. INFORMANT E. L. Rager, Columbia Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Philadelphia Mo DATE Mar 11 1935

19. UNDERTAKER B. M. Allen Philadelphia Mo

20. FILED Mo 14 1935 R. H. Schotes

Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar 9 1935

22. I HEREBY CERTIFY, That I attended deceased from Mar 7 1935 to Mar 9 1935

I last saw her alive on Mar 5 1935 Death is said to have occurred on the date stated above, at 2:45 P. M.

The principal cause of death and related causes of importance were as follows:

Dilatation of Pulmonary Vessels acute dilatation of heart

Date of onset

Other contributory causes of importance:

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

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? _____

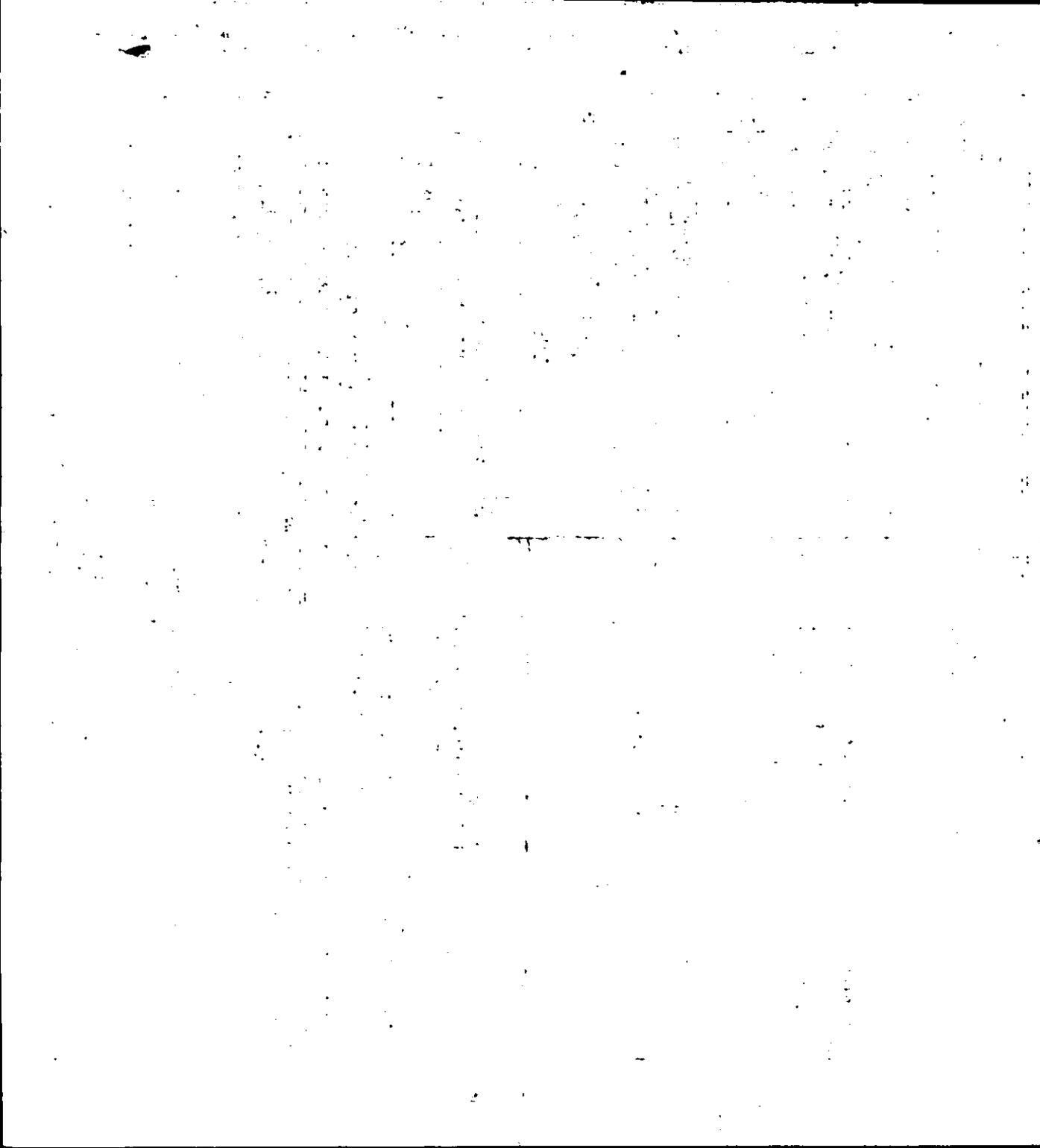
If so, specify _____

(Signed) A. J. Shanks, M. D.

(Address) Hannibal 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.

OCCUPATION
FATHER
MOTHER



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BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

9828

1. PLACE OF DEATH

County Marion
Township
City Hampdal (No. _____)

Registration District No. 547
Primary Registration District No. 3029

File No. _____
Registered No. 80 St. _____ Ward)

2. FULL NAME

Lillian Catherine Rayon

(a) Residence, No. _____ St. _____ Ward. _____

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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) M

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. 65 2 2

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.
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)

DECEASED

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

13. NAME

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

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE _____ DATE _____ 19

19. UNDERTAKER (ADDRESS)

20. FILED July-16-35

Edna Lueder
Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mich 9 1935

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____.

I last saw him/her alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:

Dilation of Pulmonary Arteries
acute dilation of Heart

Date of onset

Other contributory causes of importance: 9828
Chronic Myocarditis

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____

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) _____, M. D.

(Address) _____

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

JUL 10 1925

59828