

REG NOV 16 1936

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

34328
Do not use this space.

1. PLACE OF DEATH

(a) County Registration District No. **791**
 (b) Township Primary Registration District No. **1008** Registered No. **9314**
 (c) City *St. Louis, Mo.* (d) Street No. **ANNEXES HOSPITAL** St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME *Madalyn Sara Lilly*

(a) Residence, No. *1008 Edge wood DR.* St. **N.R. Charleston, West Virginia.**
 (Usual place of abode, if no street address, write county or city) (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 Preston Lilly*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Feb. 16, 1902*

7. AGE	YEARS	MONTHS	DAYS	IF LESS THAN 1 day,hrs. ormin.
	<i>36</i>	<i>8</i>	<i>6</i>	

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

12. BIRTHPLACE (CITY OR TOWN) *Thomas*
 (STATE OR COUNTRY) *West Virginia*

13. NAME *Thornton S. McGintire*

14. BIRTHPLACE (CITY OR TOWN) *Thomas*
 (STATE OR COUNTRY) *West Virginia*

15. MAIDEN NAME *Stella Unknown*

16. BIRTHPLACE (CITY OR TOWN) *Thomas*
 (STATE OR COUNTRY) *West Virginia*

17. INFORMANT (NAME) *John P. Lilly*
 (ADDRESS) *Charleston, West Virginia*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Charleston West* DATE *Oct. 23rd 1936*

19. FUNERAL DIRECTOR (NAME) *W. R. Lupton & Sons*
 (ADDRESS) *7233 Delmar*

20. FILED **OCT 27 1936** *J. Breck* Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *10-22-38*, 19

22. I HEREBY CERTIFY, That I attended deceased from *10-19-38*, 19, to *10-22-38*, 19

I last saw h.s. alive on *10-22-38*, 19. Death is said

to have occurred on the date stated above, at *2:15* p.m.

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

Pulmonary Tuberculosis Date of onset ?

Other contributory causes of importance:

Name of operation *Thoracoplasty* Date of *10-22-38*

What test confirmed diagnosis? *sp. sm.* Was there an autopsy? *Yes*

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? *1*

_____ specify _____

(Signed) *Carl E. Fischer*, M. D.

(Address) *BARNES HOSPITAL*

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.

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, _____

Clarence H. Murray

or by _____

Registered Apprentice No. _____, working under my personal supervision.

Signed

Clarence H. Murray

Licensed Embalmer No. *4011*

P. O. Address *St. Louis, Mo*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.