

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

14889  
 Do not use this space.

REC'D MAY 11 1939

1. PLACE OF DEATH  
 (a) County GREENE Registration District No. 316  
 (b) Township \_\_\_\_\_ Primary Registration District No. 2001 Registered No. 322  
 (c) City SPRINGFIELD (d) Street No. Springfield Baptist 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 467) Ransom Lucke Tilley  
 (a) Residence, No. Plato, Missouri St.   
 (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 male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) child

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov. 13, 1934

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
 4 5 2

OCCUPATION 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. Child  
 10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

FATHER 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Plato Missouri  
 13. NAME W. L. Tilley  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Columbia Missouri

MOTHER 15. MAIDEN NAME Grace Luke  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Nebraska

17. INFORMANT W. L. Tilley (ADDRESS) Plato, Missouri

18. BURIAL, CREMATION, OR REMOVAL PLACE Lynch Cemetery DATE April 16, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Elliott Funeral Home Cabool, Missouri

20. FILED Apr 15 1939 Chas. A. George (Address) Springfield, Mo.  
 Local Registrar. 290

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 15, 1939

22. I HEREBY CERTIFY, That I attended deceased from 4-6, 1939, to 4-15, 1939  
 I last saw him alive on April 15, 1939. Death is said to have occurred on the date stated above, at 7:30 a.m.  
 The principal cause of death and related causes of importance were as follows:  
Diverticulitis cecum-greene.  
Peritonitis  
 Date of onset 4-8-39  
12 30  
4-9-39

Other contributory causes of importance: \_\_\_\_\_

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ 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? No  
 If so, specify \_\_\_\_\_  
 (Signed) Arthur Busch, M. D.  
Springfield, Mo.

**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, or by.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed *L. D. Gorman*

Licensed Embalmer No. *3177*

P. O. Address *Springfield*

**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.**

X