

REC'D OCT 12 1939

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

32784

Do not use this space.

1. PLACE OF DEATH

(a) County Laclede Registration District No. 449
(b) Township 1 Primary Registration District No. 5618
(c) City 1 or (d) Street No. _____ St. _____
(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

Mrs. Jasper Lillard
(a) Residence, No. _____ St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec 15 1856

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
82 8 13

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. Farmer
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) Laclede Co Mo13. NAME Daniel Lillard14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Jenn15. MAIDEN NAME Sarah Stone16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ill17. INFORMANT (ADDRESS) Mr. Bittie Lillard
Reberson Mo18. BURIAL, CREMATION, OR REMOVAL PLACE Lillard Cem DATE 8/30/3919. FUNERAL DIRECTOR (NAME) (ADDRESS) W. E. Holman
Reberson Mo20. FILED 9-17-39 J. A. McCoubert
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8/28/3922. I HEREBY CERTIFY, That I attended deceased from 4-29-39 to 8-28-39I last saw h. _____ alive on 8-27-39. Death is said to have occurred on the date stated above, at 9:30 P.M.

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

Chronic Nephritis

Date of onset

Other contributory causes of importance: 121

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) J. A. McCoubert, M. D.(Address) 407

(Licensed Embalmer's Statement on Reverse Side)

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

300-4-19-35 I X-16605

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.

RECEIVED

District Health Officer No. 7;

District File Number 7-39-1386

Date Filed 10-9-39

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 Myself
....., Registered Apprentice No.....

working under my personal supervision.

Signed W.E. Salinan

Licensed Embalmer No. 4107

P. O. Address Lubaton 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.