

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.

FILED FEB 3 1940

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

4011  
Do not use this space.

1. PLACE OF DEATH  
 (a) County Stoddard Registration District No. 837  
 (b) Township Castor Primary Registration District No. 6899  
 (c) City 0 (d) Street No. 0 (If death occurred in Hospital or Institution, write its name instead of street and number) 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 Lizzie Layton  
 (a) Residence, No. Castor Township Stoddard Co. R. R. (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 F 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug. 29, 1866

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
73 4 8

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

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-7-1940

22. I HEREBY CERTIFY, That I attended deceased from Dec 1, 1939 to Jan 6, 1940  
 I last saw her alive on Jan 6, 1940. Death is said to have occurred on the date stated above, at 4: A. m.  
 The principal cause of death and related causes of importance were as follows:  
Pneumonia, Chronic  
 Date of onset Several years

Other contributory causes of importance:  
Chronic pneumonia 2 who!

Name of operation None Date of None  
 What test confirmed diagnosis? None 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? No  
 If so, specify \_\_\_\_\_  
 (Signed) J. H. Harris, M. D.  
 (Address) Bloomfield, Mo.

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

FATHER  
 13. NAME David Lewis  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

MOTHER  
 15. MAIDEN NAME Mary Cooper  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

17. INFORMANT (ADDRESS) Mrs. Wm. Meigs  
Bloomfield, Mo.

18. BURIAL, CREMATION, OR REMOVAL  
 PLACE Walker Cem. DATE Jan. 9, 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Chiles Funeral Service  
Bloomfield, Mo.

20. FILED 19 Jan 16  
 Local Registrar.

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

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**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.**