

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

6555

Do not use this space.

FILED FEB 12 1940

1. PLACE OF DEATH *Franklin*  
 (a) County Washington Registration District No. 2  
 (b) Township 2 Primary Registration District No. 294 Registered No. \_\_\_\_\_  
 (c) City \_\_\_\_\_ or \_\_\_\_\_ (d) Street No. 1114 St. \_\_\_\_\_  
 (e) Length of residence in city or town where death occurred \_\_\_\_\_ yrs. mos. da. (f) How long in U. S., if of foreign birth? \_\_\_\_\_ yrs. mos. da.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)

2. PRINT FULL NAME Lillie Jane Northcutt  
 (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 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 Phillip Northcutt  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 10, 1886  
 7. AGE YEARS 53 MONTHS 5 DAYS 20 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
 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 \_\_\_\_\_  
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Crawford Co, Mo.  
 FATHER 13. NAME C. W. Hulder  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Washington Co, Mo.  
 MOTHER 15. MAIDEN NAME Eliza Wallis  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo. 15  
 17. INFORMANT (ADDRESS) Phillip Northcutt  
Sullivan, Mo.  
 18. BURIAL, CREMATION, OR REMOVAL PLACE New Hope DATE Feb. 1, 1940  
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) \_\_\_\_\_  
 20. FILED Feb. 9, 1940 H. H. Duckworth  
Local Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 30, 1940  
 22. I HEREBY CERTIFY, That I attended deceased from Jan 29, 1940, to Jan 30, 1940.  
 I last saw him alive on Jan 30, 1940. Death is said to have occurred on the date stated above, at 5 P. M..  
 The principal cause of death and related causes of importance were as follows:  
Carcinoma of Lung  
 Date of onset ?  
 Other contributory causes of importance: H7  
 Name of operation Colic 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? no  
 If so, specify \_\_\_\_\_  
 (Signed) W. H. Duckworth M. D.  
 (Address) Dr. Conner

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.

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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.**