DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 7823

Registration District No. 703 Primary Registration District No. 5932 Registrar's No.

1. PLACE OF DEATH:

(a) County Polk

(b) City or town Humansville (Rural)
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 9
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days) 11

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town
(If outside city or town limits, write "RURAL")

(d) Street No.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME SAMUEL M. TILLERY

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Dec (Month) 9 (Day) 1865 (Year)

8. AGE: Years 74 Months Days 21 If less than one day hr. min.

9. Birthplace Mo (City, town, or county) Mo (State or foreign country)

10. Usual occupation Farmer

11. Industry or business

FATHER
12. Name Harris Tillery
13. Birthplace Mo (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Mary Barnett
15. Birthplace Ky (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Harlin Wright
(b) Address Humansville Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 2, 1940 (Month) (Day) (Year)
(c) Place: burial or cremation City Cemetery

18. (a) Signature of funeral director Joseph F. Finestone
(b) Address Humansville Mo

19. (a) Mar. 9, 1940 (Date received local registrar) (b) Ora M. Rich (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 30
year 1939 hour 2 minute 15 A.M.

21. I hereby certify that I attended the deceased from Nov, 1939, to Dec 30, 1940;
that I last saw him alive on Dec 29, 1940
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Chronic Cystitis	3 yrs
~~Carcinoma of~~	
Due to: Anemia & Sepsis	3 wks
Due to: absorption of bladder	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy none	

PHYSICIAN — Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work? (e) Means of injury

23. Signature R. C. Neerins (M. D. or other)
Address Humansville Mo Date signed 2-6-40

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

Rev. 5-17-39 I X19511

RECEIVED
District Health Officer No. 7
District File Number 3-40-457
Date Filed 3-13-40

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 Ralph A. Joseph

Licensed Embalmer No. B 149

P. O. Address Humansville

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.