

Registration District No. 8270

Primary Registration District No. 4500

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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Shelby  
(b) City or town Blaine Mo  
(c) Name of hospital or institution: \_\_\_\_\_  
(if not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 1-year years, months or days

8. (a) PRINT FULL NAME Lillis Jane Roy  
8. (b) If veteran, name war \_\_\_\_\_ 8. (c) Social Security No. \_\_\_\_\_

4. Female 5. Color or race White 6. (a) Single, widowed, married, divorced \_\_\_\_\_  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Sept 28 1861 (Month) (Day) (Year)

8. AGE: Years 78 Months 5 Days 28 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation House wife

11. Industry or business \_\_\_\_\_

MOTHER { 12. Name Dr. E. H. Davis  
13. Birthplace Don't know (City, town, or county) (State or foreign country)

FATHER { 14. Maiden name Susan Day  
15. Birthplace Don't know (City, town, or county) (State or foreign country)

16. (a) Informant John Cox  
(b) Address Blaine Mo

17. (a) Hannibal Mo (Burial, cremation, or other) (b) Date thereof 3-11-40 (Month) (Day) (Year)  
(c) Place: burial or cremation Hannibal Mo

18. (a) Signature of funeral director E. H. Hopper  
(b) Address Blaine Mo

19. (a) 2-29-1940 (Date received local registrar) (b) Roy Hamilton (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Shelby  
(c) City or town Hannibal Mo (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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 28  
year 1940 hour 10:45 minute 45 AM.  
21. I hereby certify that I attended the deceased from Jan 10  
1939 to Feb 28, 1940  
that I last saw her alive on Feb 27, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral apoplexy of  
Fractured hip right  
Due to \_\_\_\_\_ 1 month  
Due to \_\_\_\_\_ 1 year  
Other conditions (Include pregnancy within 3 months of death) gout

Major findings: Of operations none  
Of autopsy none

Duration  
1 month  
1 year  
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) no  
(b) Date of occurrence no  
(c) Where did injury occur? no (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
While at work? no (Specify type of place) (e) Means of injury no  
23. Signature D. L. Hailan (M. D. or other) M.D.  
Address Clarence Mo Date Feb 29 1940

RECEIVED

District Health Officer No. 10

District File Number 3-40-678

Date Filed MAR 13 1940

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 *E E Hopper*.....

Licensed Embalmer No. *978*.....

P. O. Address *Bellevue W*.....

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.