V. S. No. 2
M—11-10-39
ev. 5-17-39
I X21492

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

FEB APR 15 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 9903 1337

Registration District No. 399 Primary Registration District No. 1002 Registrar's No.

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution: 1015 East 27th St
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 (Specify whether years, months or days)

In this community Since Aug. 19th 1936

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

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

(d) Street No. 1015 East 27th Street
(If rural, give location)

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

3. (a) PRINT FULL NAME Mrs. Winifred Lillard 463

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife John Stacy Lillard

6. (c) Age of husband or wife if alive 42 years

7. Birth date of deceased March 1st, 1903 (Month) (Day) (Year)

8. AGE: Years 37 Months 0 Days 22 If less than one day ____ hr. ____ min.

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

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Archie Englehardt
13. Birthplace No Record (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name No Record
15. Birthplace No Record (City, town, or county) (State or foreign country)

16. (a) Informant John Stacy Lillard
(b) Address 1015 East 27th St

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-26-40 (Month) (Day) (Year)
(c) Place: burial or cremation Greenlawn

18. (a) Signature of funeral director Jo W. Wagner
(b) Address Kansas City Mo.

19. (a) Mch 26, 1940 (Date received local registrar) (b) M. M. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 23rd year 1940 hour ____ minute 7 00 P.M.

21. I hereby certify that I attended the deceased from ____, 19____, 19____; that I last saw him alive on ____, 19____; and death occurred on the date and hour stated above.

Cancer

Immediate cause of death — Duration

Sunstat wound of head

Due to 1167

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

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) Suicide
(b) Date of occurrence 3-23-40
(c) Where did injury occur? K.C. Mo (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? 3 1
(e) While at work? (Specify type of place) (f) Nature of injury

23. Signature Arthur L. Mueller (M. D. or other)
Address K.C. Mo Date signed

(Licensed Embalmer's Statement on Reverse Side)

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 Cecil. R. Matthes, Registered Apprentice No. _____, working under my personal supervision.

Signed Cecil R. Matthes

Licensed Embalmer No. 3809

P. O. Address 204 - W. Lincoln

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.