

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED APR 4 1940
Registration District No. 4

Primary Registration District No. 5009

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Oregon
(b) City or town Rover
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: none
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 25 years and more
In this community 25 years and more
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Oregon
(c) City or town rural
(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.? Citizen years.

3. (a) PRINT FULL NAME Mrs. Manda Lile
3. (b) If veteran, name war no
3. (c) Social Security No. no

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month March day 16
year 1940 hour _____ minute _____ M.

4. Sex Female 5. Color or race white
6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Jan. 22, 1863
(Month) (Day) (Year)

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

8. AGE: Years 77 Months 1 Days _____ If less than one day _____ hr. _____ min.

Immediate cause of death old age
Due to _____
Due to _____

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

Other conditions _____
(Include pregnancy within 3 months of death)
Major findings: _____
Of operations _____
Of autopsy _____

10. Usual occupation Housewife
11. Industry or business none

MOTHER FATHER
12. Name Marcus Lile
18. Birthplace Oregon Co Mo
(City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace Oregon Co Mo
(City, town, or county) (State or foreign country)

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? _____
While at work? _____ (Specify type of place) (e) Means of injury _____

16. (a) Informant's own signature _____
(b) Address _____

17. (a) burial (b) Date thereof 3-21-1940
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Oregon Co. Mo.

18. (a) Signature of funeral director No licensed director
(b) Address N.F. Haywood, Rover, Mo. (acting)

19. (a) 3-29-1940 (b) Mrs. Maggie Willard
(Date received local registrar) (Registrar's signature)

23. Signature _____ (M. D. or other)
Address _____ Date signed _____

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

Rev. 5-17-39
1 x19311

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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RECEIVED FILED STATE OFFICE
INDEX CARD RETURNED TO DISTRICT

DATE

APR 8 - 1964

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 11896

Registration District No. 634

Primary Registration District No. 2837

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Oregon
(b) City or town Highland, T.P.
(If outside city or town limits, write "RURAL" and name of township)
(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 _____
years, months or days)

3. (a) PRINT FULL NAME Mrs. Manda Lile

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex 7 5. Color or race w 6. (a) Single, widowed, married, divorced and

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased 1 - 22 - 1863
(Month) (Day) (Year)

8. AGE: Years 77 Months _____ Days _____
If less than one day _____ hr _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

13. Birthplace _____
(City, town, or county) (State or foreign country)

14. Maiden name _____
(City, town, or county) (State or foreign country)

15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant _____
(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____

19. (a) _____ (b) Mrs. A. E. Willard
(Date received local registrar) (Registrar's signature)

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.

20. DATE OF DEATH Month 3 day 16
year 1940 hour _____ minute _____ M.

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

Due to _____
Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

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?
While at work? _____
(Specify type of place) (c) Means of injury _____

23. Signature Mrs. A. E. Willard (M. D. or other) _____
Address 1204 Broadway Mo Date signed Jan 21

SUPPLEMENTAL

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

DEPARTMENT OF COMMERCE - BUREAU OF THE CENSUS - MAKE A PERMANENT RECORD

11896 (1940)

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