

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.

Registration District No. 290

Primary Registration District No. 6408

Registrar's No. _____

1. PLACE OF DEATH:
(a) County Dunklin, Mo.
(b) City or town Marion
(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 Jimmie Dale Lillard
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

4. Sex M 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 1938
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>11</u>	<u>5</u>	<u>8</u>	hr. _____ min. _____

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

10. Usual occupation Infant

11. Industry or business _____

12. Name Jimmie Dale Lillard
13. Birthplace Dunklin, Mo.
(City, town, or county) (State or foreign country)

14. Maiden name Anna Phelps
15. Birthplace Marion, Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature _____
(b) Address 212 S. 1st

17. (a) Burial (b) Date thereof 3-7-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Funeral Home
18. (a) Signature of funeral director W. Daniel James
(b) Address Funeral Home

19. (a) Mar. 3-1940 (b) A. A. McDaniel
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Dunklin
(c) City or town Marion
(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 3 day 6
year 1940 hour 8 minute 30 P. M.

21. I hereby certify that I attended the deceased from 3-5-40, 1940, to 3-6-40, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Infant Paralysis (Cerebral Polio myelitis)
Due to _____
Duration 3-3-40
Due to 16

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) _____
(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 W. Daniel James (M. D. or other) MD
Address Funeral Home Date signed 3-6-40

RECEIVED

District Health Officer No. 2,

District File Number 540-1046

Date Filed 5/15/40

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.....

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

State File No. 14810

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 290

Primary Registration District No. 5408

Registrar's No.

1. PLACE OF DEATH:

(a) County Dunklin
(b) City or town Salem
(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 _____ (Specify whether
years, months or days)

3. (a) PRINT FULL NAME Jimmie Dale Hillard
(b) If veteran, name was _____
(c) Social Security No. _____

4. Sex m (5. Color White)
6. (a) Single, widowed, married, divorced Infant
6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
1 5 8 hr. min.

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

10. Usual occupation

11. Industry or business

12. Name

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

14. Maiden name

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

16. (a) Informant Joseph Hillard

(b) Address Revels

17. (a) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) May 3 1940 (Date received local registrar) A. P. McDavid (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 1
year _____ hour _____ minute _____ M.

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.
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) (e) Means of injury

23. Signature Roy E. Spindel (M. D. or other)

Address Spindels Date signed _____

MEDICAL CERTIFICATION

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTAL

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

290

S-14810