

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

19051

Do not use this space.

1. PLACE OF DEATH

(a) County Monroe Registration District No. 587
 (b) Township Woodlawn Primary Registration District No. 1585- Registered No. 20-
 (c) City or Duncans Bridge (d) Street No. _____ St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME J. Gable Lilly

(a) Residence, No. Americus Rd. in MD St. (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug. 30 1855

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
84 8 27

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer
 9. Industry or business in which work was done, as saw mill, bank, etc. _____
 10. Date deceased last worked at this occupation (month and year) 1909 11. Total time (years) spent in this occupation 60

12. BIRTHPLACE (CITY OR TOWN) Missouri (STATE OR COUNTRY) 0

FATHER 13. NAME Gable Lilly

14. BIRTHPLACE (CITY OR TOWN) Virginia (STATE OR COUNTRY) 9

MOTHER 15. MAIDEN NAME Mary Medley

16. BIRTHPLACE (CITY OR TOWN) Don't know (STATE OR COUNTRY)

17. INFORMANT Wailes Lilly (ADDRESS) Duncans Bridge No.

18. BURIAL, CREMATION, OR REMOVAL PLACE Phillips Cemetery DATE May 28 1940

19. FUNERAL DIRECTOR (NAME) E. Hays (ADDRESS) Phillips and

20. FILED May 28 1940 Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 27 1940 1940

22. I HEREBY CERTIFY, That I attended deceased from June 11 1936 to May 27 1940

I last saw him alive on May 25 1940, 1940. Death is said to have occurred on the date stated above, at 9:30 a.m.
 The principal cause of death and related causes of importance were as follows:

Chronic Myocarditis 1936
Due to
Arteriosclerosis 1930

Other contributory causes of importance: none

Name of operation none Date of _____
 What test confirmed diagnosis? none Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? no Date of injury _____, 1940
 Where did injury occur? no (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place. no

Manner of injury none
 Nature of injury none

24. Was disease or injury in any way related to occupation of deceased? no
 If so, specify _____

(Signed) D. L. Harlan, M. D.
 (Address) Clarence, Mo.

WRITE PAINLY, WITH UNFADING INK---THIS IS 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.

1 X18605

RECEIVED

District Health Officer No. 10

District File Number 6-40-1214

Date Filed JUN 12 1910

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 Hayes*

Licensed Embalmer No. 1437

P. O. Address Shelbina mo

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.

No. 2B
2-21-4
I X
WENA MOORE

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 19057

Registration District No. 587

Primary Registration District No. 15-85-

Registrar's No.

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

1. PLACE OF DEATH:

(a) County. Monroe

(b) City or town. Woodlawn
(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 James Hable Lilly

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

4. Sex m 5. Color or race w

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

6. (b) Name of husband or wife..... 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

84 8 27 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.....

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

16. (a) Informant.....

(b) Address.....

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

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) May 17 - 1940 (Date received local registrar) (b) Frank Widdling (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.

MEDICAL CERTIFICATION

20. DATE OF DEATH. Month May day 27 year 1940 hour..... minute..... M.

21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....; that I last saw h..... alive on..... 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 D. L. Harlan (M. D. or other).....

Address Claremont Date signed.....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTAL COPY

S-19051