

Registration District No. 250

Primary Registration District No. 4150

Registrar's No. 18

1. PLACE OF DEATH:
(a) County Daviess
(b) City or town Gallatin
(c) Name of hospital or institution: _____
(If outside city or town limits, write "RURAL", and name of township) 2
(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) 1 1/2

2. USUAL RESIDENCE OF DECEASED:
(a) State 0 mo
(b) County Daviess
(c) City or town Gallatin
(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.

3. (a) PRINT FULL NAME Lillie Viola Parker
3. (b) If veteran, name war None
3. (c) Social Security No. None

4. Sex F 5. Color or race w
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Wm Parker
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Nov 7 1864
(Month) (Day) (Year)

8. AGE: Years 75 Months 8 Days 9
If less than one day _____ hr. _____ min.

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

10. Usual occupation Retired

11. Industry or business
MOTHER FATHER { 12. Name Wm Hulcomb
13. Birthplace Mo
14. Maiden name Christina Hulcomb
15. Birthplace Mo
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs Vera Beyer
(b) Address Gallatin Mo
17. (a) burial (b) Date thereof Aug 18-40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Gallatin Mo
18. (a) Signature of funeral director Gipsoids
(b) Address Trenton Mo
19. (a) August 17-1940 (b) H. H. Hope
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Aug day 16
year 1940 hour 6 PM minute _____ M.
21. I hereby certify that I attended the deceased from 8-13-40 to 8-16-40
that I last saw her alive on 8-16 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Myocarditis Duration 2 mos.
Due to Fatigue due to
Due to exclusive trip.
Other conditions _____
(Include pregnancy within 3 months of death) 92H

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? 227
While at work? _____ (Specify type of place)
(e) Manner of injury _____
23. Signature Floyd E. Helton (M.D. or other)
Address Gallatin Date signed 8-17-40

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.

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..... *Shaw W. Gajna*

Licensed Embalmer No. *3109*

P. O. Address *Newton ma*

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.