

Registration District No. 87

Primary Registration District No. 7-8-1-5787

Registrar's No. 10

1. PLACE OF DEATH:

(a) County Monroe Co
 (b) City or town Duaneau Bridge
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Woodlawn Trng
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution all his life (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Monroe Co
 (c) City or town Duaneau Bridge
 (If outside city or town limits, write "RURAL")
 (d) Street No. 0 (If rural, give location)
 (e) If foreign born, how long in U. S. A? 0 years.

3. (a) PRINT FULL NAME

Charles William Lilly3. (b) If veteran, name war. ✓3. (c) Social Security No. ✓4. Sex male 5. Color or race nr 6. (a) Single, widowed, married, divorced ✓6. (b) Name of husband or wife. ✓ 6. (c) Age of husband or wife if alive 21 years7. Birth date of deceased. April-21-1861
(Month) (Day) (Year)8. AGE: Years 80 Months 9 Days 4 If less than one day hr. ✓ min. ✓9. Birthplace Randolph Co Mo. (City, town, or county) (State or foreign country)10. Usual occupation farmer

11. Industry or business

MOTHER FATHER
 12. Name James Lilly
 13. Birthplace 1 Ky. (City, town, or county) (State or foreign country)
 14. Maiden name Margaret Orr
 15. Birthplace 1 Va (City, town, or county) (State or foreign country)

16. (a) Informant Mrs W C. Eyer(b) Address Chatterlee MO17. (a) buried (b) Date thereof July 27-41
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Phillip Cemetery18. (a) Signature of funeral director. W. H. H. H.(b) Address Chatterlee Mo19. (a) July 26 (b) W. H. H. H.
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 25 year 1941 hour 12 minute 30 P.M.21. I hereby certify that I attended the deceased from July 20 1941 to July 26 1941that I last saw him alive on July 24 1941 and that death occurred on the date and hour stated above.Immediate cause of death Fracture of Right Hip Duration 5 daysDue to fall from chair when attempting to sit downDue to fall from chair when attempting to sit down

Other conditions (include pregnancy within 3 months of death)

Major findings:

Of operations 1956Of autopsy 27

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) accident(b) Date of occurrence July 19 1941(c) Where did injury occur? Clarence TPO Monroe Mo
(City or town) (County) (State)(d) Did injury occur in or about home, on farm, in industrial place, in public place?
in home of daughter Mrs. Willie Eyer, ClarenceWhile at work? no (Specify type of place) (e) Means of injury fall from chair23. Signature W. H. H. H. (M. D. or other) MDAddress Clarence Mo Date signed Aug 9 1941

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

RECEIVED

District Health Officer No. 10

District File Number 8-41-1593

Date Filed AUG 21 1941

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 the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 28903
Registrar's No.

Registration District No. 587

Primary Registration District No. 5787

1. PLACE OF DEATH:

(a) County Monroe
(b) City or town Duncans Bluff
(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
In this community all of life (Specify whether years, months or days)

3. (a) PRINT FULL NAME Charles W. 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 widowed
6. (b) Name of husband or wife 6. (c) Age of husband or wife if alive years
7. Birth date of deceased June 21 1864
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day 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) (Date received local registrar) (b) (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) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July Day 24 year 1941 hour minute M.

21. I hereby certify that I attended the deceased from 19.....; that I first 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

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 (M. D. or other) Address Date signed

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

SUPPLEMENTARY

