

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 35335

Registration District No. 449

Primary Registration District No. 5618

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Laclede
(b) City or town Brownfield, Mo. Rural, Osage
(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) 1
(d) Length of stay: In hospital or institution 80 years (Specify whether years, months or days)
In this community 80 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Laclede
(c) City or town Brownfield Rural
(If outside city or town limits, write "RURAL")
(d) Street No. R Osage (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country D

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 28
year 1941 hour 4 minute 30 A.M.
21. I hereby certify that I attended the deceased from July 1
1939 to Oct 20, 1941
that I last saw him alive on Oct 20, 1941
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage
Due to arterio-sclerosis
Due to _____
Other conditions Senile Dementia
(include pregnancy within 3 months of death)

Duration

PHYSICIAN

Major findings:
Of operations _____
Of autopsy 430
Underline the cause to which death should be charged statistically.

3. (a) PRINT FULL NAME JOSEPH WARREN LILLARD

3. (b) If veteran, name war _____ 3. (c) Social Security No. none

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced, married
6. (b) Name of husband or wife Anna L. Lillard 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Oct 21 1861
(Month) (Day) (Year)

8. AGE: Years 80 Months 7 Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER { 12. Name Daniel Lillard ;
13. Birthplace Ill. ;
(City, town, or county) (State or foreign country)
14. Maiden name Mrs. Sarah A. Stone
15. Birthplace Ill. ;
(City, town, or county) (State or foreign country)

16. (a) Informant Anna L. Lillard
(b) Address Brownfield Mo

17. (a) burial (b) Date thereof Oct 30 1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cross Roads Cemetery

18. (a) Signature of funeral director W. E. Holman

(b) Address Lebanon Mo

19. (a) 11-3-41 (b) J. H. Conner
(Date received local registrar) (Registrar's signature)

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 R. Gaston (M. D. or other) D. O.
Address Ruby Mo Date signed 10-29-41

404 (Licensed Embalmer's Statement on Reverse Side)

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

3
0
0

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 Dorsey M. Howe
Licensed Embalmer No. 4222
P. O. Address Lebanon, 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, fact should be so stated above.