

**FILED**  
MAR 13 1943

Registration District No. 297

Primary Registration District No. 3057

Registrar's No. 7

1. PLACE OF DEATH:

(a) County Ray  
(b) City or town Richmond Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: none  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution none  
In this community All Her Life (Specify whether years, months or days)

3. (a) PRINT FULL NAME MARY LILE

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife ..... 6. (c) Age of husband or wife if alive ..... years

7. Birth date of deceased Sept. 3 rd. 1875.  
(Month) (Day) (Year)

8. AGE: Years 67 Months 5 Days 18 If less than one day hr. min.

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

10. Usual occupation House Keeper

11. Industry or business

MOTHER FATHER { 12. Name James Lewis Lile  
13. Birthplace Ray Co. Mo.  
(City, town, or county) (State or foreign country)  
14. Maiden name Virginia Ann Harwood  
15. Birthplace Texas  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. A. P. Bummer

(b) Address Rayville Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-24-43.  
(Month) (Day) (Year)

(c) Place: burial or cremation Union Cem. Ray Co. Mo.

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

(b) Address Richmond Mo.

19. (a) Feb 23 1943 (Date received local registrar) (b) Mrs. Shes W. Shippard (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Ray  
(c) City or town Richmond Mo.  
(If outside city or town limits, write "RURAL")  
(d) Street No. 215 Camden Street  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country U.S.A.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 21 st.  
year 1943. hour 3-30 minute A. M.

21. I hereby certify that I attended the deceased from Feb 15 to Feb 20, 1943 that I last saw her alive on Feb 19, 1943 and that death occurred on the date and hour stated above.

Immediate cause of death Fractured Hip  
Duration

Due to .....

Due to .....

Other conditions .....  
(Include pregnancy within 5 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) 089V

(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 E. D. Green (M. D. or other)

Address Richmond Mo. Date signed

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

RECEIVED

RECEIVED

District Health Officer No. 8,

Case File Number

Filed

3-12-43

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

J. B. Brothers

Registered Apprentice No.

working under my personal supervision.

Brothers Funeral Home,

Signed

J. B. Brothers

Licensed Embalmer No. 2001.

P. O. Address Richmond 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.

B  
41  
88

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 7392

Registration District No. 297

Primary Registration District No. 3057

Registrar's No. 7

1. PLACE OF DEATH:

(a) County Ray  
 (b) City or town Richmond  
(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

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 \_\_\_\_\_

3. (a) PRINT FULL NAME Mary Lee  
 3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_  
 4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced S  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased Sept 3  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July Day 12 Year 1943 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
 21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; that I last saw him/her alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death fracture of hip Duration \_\_\_\_\_

8. AGE: Years 69 Months 5 Days 18 If less than one day \_\_\_\_\_ min.  
 9. Birthplace Ray, Mo.  
(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)

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions (include pregnancy within 5 months of death) \_\_\_\_\_  
 Major findings: Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_

MOTHER FATHER {  
 16. (a) Informant \_\_\_\_\_ (b) Address \_\_\_\_\_  
 17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation \_\_\_\_\_  
 18. (a) Signature of funeral director \_\_\_\_\_ (b) Address \_\_\_\_\_  
 19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(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) Accident  
 (b) Date of occurrence Feb 15 - 43  
 (c) Where did injury occur Home Richmond Ray Mo  
(City or town) (County) (State)  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? fall from chair  
(Specify type of place)  
 While at work? no (e) Means of injury fall  
 23. Signature E. D. Green (M. D. or other) \_\_\_\_\_  
 Address Richmond Mo Date signed 7-31-43

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

SUPPLEMENTARY

PHYSICIAN  
Underline the cause to which death should be charged statistically.

