

S. No. 2  
OM-5-42  
v. 5-17-38  
FILED

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 13276  
1984  
Registrar's No.

MAY 6 1943

Registration District No. 149

Primary Registration District No. 1002

1. PLACE OF DEATH:  
(a) County **Jackson**  
(b) City or town **Kansas City**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**St. Joseph's Hospital**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **8 Days** (Specify whether  
In this community **70 years** (Specify whether  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Missouri** (b) County **Jackson**  
(c) City or town **Kansas City**  
(If outside city or town limits, write "RURAL.")  
(d) Street No. **7410 Wayne** (If rural, give location)  
(e) Citizen of foreign country? (Yes or No)  
If yes, name country.

3. (a) PRINT FULL NAME **Mary Ellen Lillis**  
3. (b) If veteran, name war. **no** 3. (c) Social Security No. **none**

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **April** day **26th.**  
year **1943** hour minute M.

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**  
6. (b) Name of husband or wife **James F. Lillis** 6. (c) Age of husband or wife if alive **76** years  
7. Birth date of deceased **May 30 1867**  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **Pathologist** to **19**;  
that I last saw him alive on **19**;  
and that death occurred on the date and hour stated above.  
Immediate cause of death **Coronary failure**

8. AGE: Years Months Days If less than one day  
**75 10 27 1/2** hr. min.

Due to **Coronary occlusion**  
Due to **Generalized arterio-sclerosis**

9. Birthplace **Howell Massachusetts**  
(City, town, or county) (State or foreign country)

Other conditions (Include pregnancy within 3 months of death) **gca**

10. Usual occupation **Housewife**

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

11. Industry or business

12. Name **John Milan**

13. Birthplace **Ireland**  
(City, town, or county) (State or foreign country)

14. Maiden name **Elizabeth O'Seary**

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

16. (a) Informant **MacLillis**  
(b) Address **7410 Wayne**

17. (a) **Burial** (b) Date thereof **4-28-43**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **St. St. Mary's Cemetery**

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 **Wm. R. Ketcham** (M. D. or other)  
Address **Braine, Shawnee, Mo.** Date signed **17**

18. (a) Signature of funeral director **[Signature]**  
(b) Address **3256 Broadway**  
19. (a) **4-27-43** (b) **M. M. Brown**  
(Date received local registrar) (Registrar's signature)

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

MOTHER FATHER

**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 Park G. Rowe

Licensed Embalmer No. 2347

P. O. Address T. C. 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.**