

No. 2
-2-43
-17-39
X35697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

24824

State File No.

Registrar's No. 126

FILED AUG 7 1943
Registration District No. 29

Primary Registration District No. 5379

1. PLACE OF DEATH:

(a) County Delaware
(b) City or town Amity Rural S.W. Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 mo (Specify whether years, months or days)
In this community 6 mo (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Michigan (b) County 999
(c) City or town Dearborn 20
(If outside city or town limits, write "RURAL")
(d) Street No. 22905 Arlington
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country 2

3. (a) PRINT FULL NAME Willie T. Lilly

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Mrs W.T. 6. (c) Age of husband or wife if alive 15 years

7. Birth date of deceased sept 3 1916
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
26 10 12 hr. min.

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

10. Usual occupation unknown

11. Industry or business _____

12. Name unknown 9

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

14. Maiden name unknown

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

16. (a) Informant Post Records
(b) Address Rosegram Field Mo

17. (a) Removal (b) Date thereof 7-16-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Dearborn, Mich

18. (a) Signature of funeral director Flora & Sons
(b) Address St Joseph Mo.

19. (a) 7-16-43 (b) Ch. Dingley
(Data received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 15
year 43 hour 9 minute 15 A.M.

21. I hereby certify that I attended the deceased from _____, 19____, 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 Multiple fractures extreme Duration _____

Due to Airplane crash

Due to _____

Other conditions (include pregnancy within 3 months of death) _____

Major findings: Of operations 173
Of autopsy 314

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 032
(b) Date of occurrence 7-15-43
(c) Where did injury occur? Rural Amity Delmo
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? Yes (Specify type of place) (c) Means of injury _____

23. Signature Edley Camp Capt Mo (M. D. or other)
Address Care Hospital Rosegram Date signed 7-16-43
Field

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

MOTHER FATHER

MAR 9 1966

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.....

Robert H. Gable

Licensed Embalmer No.....

3308

P. O. Address.....

Mr. Joseph, M.

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.

Registration District No. 99 Primary Registration District No. 0379 Registrar's No. 126

1. PLACE OF DEATH:
(a) County De Kalb
(b) City or town Rural community
(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)

3. (a) PRINT FULL NAME Walter T. 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 M

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)

8. AGE: Years 26 Months _____ Days _____ (less than one day) min.

9. Birthplace Mich. (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)

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) 7-16-43 (b) Chubb
(Date received local registrar) (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 15th
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 _____

Due to _____
Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

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 _____ (M. D. or other) _____
Address _____ Date signed _____

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

SUPPLEMENTARY

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

MAR 9 1964

MAR 10 1964

S-24824