

Registration District No. **98**

Primary Registration District No. **6023**

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

**1. PLACE OF DEATH:**

(a) County **Ray**  
(b) City or town **Knoxville**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: **1 Knoxville Hosp**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community **all his life** \_\_\_\_\_ (Specify whether)  
years, months or days)

**3. (a) PRINT FULL NAME**

**James Henry Lil**

3. (b) If veteran  name was \_\_\_\_\_  
3. (c) Social Security No. **\_\_\_\_\_**

4. Sex **M** 5. Color or race **wh.**  
6. (a) Single, widowed, married, divorced, **widowed**  
6. (b) Name of husband or wife **Lula Lil**  
6. (c) Age of husband or wife if alive **7** years  
7. Birth date of deceased **Oct. 6, 1879**  
(Month) (Day) (Year)

8. AGE: Years **63** Months **10** Days **10** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation **Merchant**

**11. Industry or business**

12. Name **Wylie Lil**  
13. Birthplace **Mo**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Mary Kincaid**  
15. Birthplace **Mo**  
(City, town, or county) (State or foreign country)

16. (a) Informant **David Lil**

(b) Address **Rayville Mo**

17. (a) **Burial** (b) Date thereof **8-17-43**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Kincaid Cemetery**

18. (a) Signature of funeral director **Alspaugh Cowley**

(b) Address **P.O. Mo**

19. (a) **8-19-43** (b) **Wasson**  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State \_\_\_\_\_ (b) County **89**  
(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL") **0**  
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 **Aug** day **16**  
year **1943** hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from **July 20**, 19**43**, to **Aug 16**, 19**43**,  
that I last saw him alive on **Aug 14**, 19**43**,  
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Hemorrhage** Duration **1 wk.**

Due to **advanced Arterio Sclerosis**

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) **83a**

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? \_\_\_\_\_

While at work \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature **Dr. James** (M. D. or other) **M.D.**

Address **Richmond Mo.** Date signed **8-19-43**

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed

9-7-43

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

....., Registered Apprentice No. ....

working under my personal supervision.

Signed

*A A Bowley*

Licensed Embalmer No. ....

1015

P. O. Address

*Polo 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.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

Registration District No. 298

Primary Registration District No. 6023

Registrar's No. 19

1. PLACE OF DEATH:

(a) County Ray  
(b) City or town Knoxville  
(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 \_\_\_\_\_ (Specify whether  
years, months or days)

3. (a) PRINT FULL NAME James Henry Lile  
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 W  
6. (b) Name of husband or wife \_\_\_\_\_  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased out 6 1943  
(Month) (Day) (Year)

8. AGE: Years 63 Months 1 Days 7 (If less than one day, \_\_\_\_\_ min.  
9. Birthplace 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)

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) W A Black  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Ray  
(c) City or town Knoxville  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug year 1943 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him \_\_\_\_\_, 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 \_\_\_\_\_

Duration \_\_\_\_\_  
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?  
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

JUL 18 1944

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