

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **38876**

**FILED DEC 10 1943**  
Registration District No. **27**

Primary Registration District No. **5917**

Registrar's No. **98**

1. PLACE OF DEATH:  
(a) County **Perry**  
(b) City or town **Yount Mo.**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: **St. Marys Hosp**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **79-7-8**  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED: **29**  
(a) State **Missouri** (b) County **Perry**  
(c) City or town **Yount Mo.**  
(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 **Henry William Lix**

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 **Lena Lix** 6. (c) Age of husband or wife if alive **75** years  
7. Birth date of deceased **April 13 1864**  
(Month) (Day) (Year)

8. AGE: Years **79** Months **7** Days **8** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace **Bollinger Co. Missouri**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

11. Industry or business \_\_\_\_\_

MOTHER FATHER {  
12. Name **John H. Lix**  
13. Birthplace **Germany**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Mary Aekemer**  
15. Birthplace **Germany**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Louis Lix**  
(b) Address **Yount Mo.**

17. (a) **Burial** (b) Date thereof **11-24-1943**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **Yount Mo.**

18. (a) Signature of funeral director **Young & Sons**  
(b) Address **Perryville, Mo.**

19. (a) **11-22-43** (b) **Doc Jelder**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **November** day **21**  
year **1943** hour **7** minute **30 P.M.**

21. I hereby certify that I attended the deceased from **Nov 21 1943**  
to **Nov 21 1943**  
that I last saw him alive on **Nov 21 1943**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Hemorrhage**  
**Arteriosclerosis**  
Due to **Hypertension**  
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 **Dr. Bailey** (M. D. or other) \_\_\_\_\_  
Address **Perryville Mo** Date signed **11-24-43**

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

1326

WRITE PLAINLY—USE UNFADING BLACK INK—MAKES EASY TO REPRODUCE

RECEIVED

District Health Officer No. 4

District File Number 1243-30

Date Filed 12-9-43

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 Wallace Young

Licensed Embalmer No. 4027

P. O. Address Perryville

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

B  
6930

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. *dec.*

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County *Perry*

(b) City or town *Gould*

(c) Name of hospital or institution \_\_\_\_\_  
(If outside city or town limits, write "RURAL" and name of township)

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)

In this community *Life* \_\_\_\_\_ (Specify whether)

years, months or days

3. (a) PRINT FULL NAME *Henry Wm. Lix*

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 \_\_\_\_\_ year \_\_\_\_\_ month \_\_\_\_\_ day \_\_\_\_\_

7. Birth date of deceased *April 13 - 1864*

(Month) (Day) (Year)

8. AGE: Years *79* Months *7* Days \_\_\_\_\_ 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 \_\_\_\_\_ (Month) (Day) (Year)

(Burial, cremation, or removal)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Registrar's signature)

(Date received local registrar)

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 *NOV* Year *1943* Day *21* Hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

*Cerebral hemorrhage*

Due to *Nephritis chronic*

Due to *Arterio sclerosis.*

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 *W. H. Bailey* (M. D. or other) \_\_\_\_\_

Address *Perryville* Date signed *11/22/43*

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

SUPPLEMENTARY

MOTHER, FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

38876