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DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 4103

FILED FEB 9 1944

Registration District No. 02

Primary Registration District No. 6041

Registrar's No. 1483

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

1. PLACE OF DEATH:
 (a) County Ripley
 (b) City or town Rural Thomas
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
2 miles south of Naylor
(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
years, months or days

2. USUAL RESIDENCE OF DECEASED: 91
 (a) State Mo. (b) County Ripley
 (c) City or town Rural
(If outside city or town limits, write "RURAL")
 (d) Street No. 2 miles south of Naylor
(If rural, give location)
 (e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME Lillian Ulene Lane

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

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 Dec. 23 1942
(Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
<u>1</u>		<u>23</u>	hr. _____ min. _____

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

10. Usual occupation _____

11. Industry or business _____

12. Name Lowell Lane

13. Birthplace Corning Ark
(City, town, or county) (State or foreign country)

14. Maiden name Glady's Molenicuff

15. Birthplace Peach Orchard, Ark.
(City, town, or county) (State or foreign country)

16. (a) Informant Lowell Lane

(b) Address Naylor, Mo.

17. (a) Burial (b) Date thereof 1/18/1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cedar Hill Ceme.

18. (a) Signature of funeral director Minnie Gish

(b) Address Naylor, Mo.

19. (a) Feb 2 - 44 (b) Bertha White
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 16
year 1944 hour 5 minute 20 P.M.

21. I hereby certify that I attended the deceased from Jan 10, 1944 to Jan 16, 1944
that I last saw him alive on Jan 15, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death fractured skull

Due to _____

Due to _____

Other conditions none
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy no

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? L
(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. E. ... M.D. (M. D. or other) _____

Address Naylor, Mo. Date signed 1/17/44

1217

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 5,

District File Number 244104

Date Filed 2-17-44

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 Bryan E. McCos

Licensed Embalmer No. 4879

P. O. Address Wright, 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. Feb

Registration District No. 202

Primary Registration District No. 6041

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Ripley
(b) City or town Rural Thomas Twp.
(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 Lillian U. Jane

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 Dec 23 1942
(Month) (Day) (Year)

8. AGE: Years 1 Months 2 Days 25 If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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) _____ (Burial, cremation, or removal) (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (Date received local registrar) (b) _____ (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 _____ year 1944 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 pneumonia

chronic

Due to _____

Due to pneumonia

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 L. E. White (M. D. or other) _____

Address _____ Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY 107

4103