

Registration District No. 155 Primary Registration District No. 3127

1. PLACE OF DEATH:  
(a) County Jasper  
(b) City or town Webb City  
(c) Name of hospital or institution Jane Chinn Hospital  
(d) Length of stay: In hospital or institution 5 days 0  
In this community 75 years

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Jasper  
(c) City or town Webb City  
(d) Street No. 114 South Main Street  
(e) Citizen of foreign country? No  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Lillie C. Roberson  
(b) If veteran, name war no  
(c) Social Security No. \_\_\_\_\_

4. Sex F. Color or race W.  
6. (a) Single, widowed, married, divorced, widowed  
6. (b) Name of husband or wife \_\_\_\_\_  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased September 9, 1868

8. AGE: Years 76 Months 3 Days 9

9. Birthplace Illinois

10. Usual occupation housework

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

12. Name James Gamon

13. Birthplace Illinois

14. Maiden name No data  
15. Birthplace Illinois

16. (a) Informant Son Russell Roberson

(b) Address Webb City, Mo.

17. (a) burial (b) Date thereof 12/20/44  
(c) Place: burial or cremation Mrs. Hazel Cemetery

18. (a) Signature of funeral director Hedge Lewis  
(b) Address Webb City, Missouri

19. (a) Dec 24 1944 (b) Mrs. Lillie Eagle  
1180 (Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month December day 18  
year 1944 hour 3:30 minute P. M.  
21. I hereby certify that I attended the deceased from Dec 14  
to Dec 18, 1944  
that I last saw her alive on Dec 18, 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis.  
Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
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? \_\_\_\_\_  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work \_\_\_\_\_  
23. Signature \_\_\_\_\_  
Address \_\_\_\_\_ Date signed 12-24-44

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

49  
6

47  
6

MOTHER FATHER

Duration

PHYSICIAN

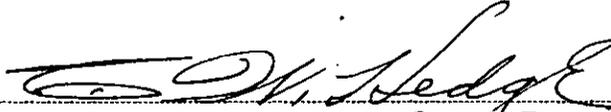
Underline the cause to which death should be charged statistically.

44-12-1121

**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 

Licensed Embalmer No. 28509

P. O. Address W. Hedge

**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:**